EDUCATION LIBRARY

EDUCATION
LIBRARY RESERVE
PERIODICAL

NOVEMBER • DECEMBER 1967

Edu

THE UNIVERSITY OF MICHIGAN
NOV 22 1967
EDUCATION LIBRARY

children

VOLUME 14 • NUMBER 6 • NOVEMBER-DECEMBER 1967

EDUCATION LIBRARY
HV741
.A362

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Spontaneous Ways of Learning in Young Children 210
Lois B. Murphy

Patterns of Change in Disturbed Blind Children in Residential Treatment 217
John R. Ross, Jr., Bernard B. Braen, and Ruth Chaput

Helping Adopting Couples Come to Grips With Their New Parental Roles 223
Edith M. Chappelear and Joyce E. Fried

The Group Process in Helping Parents of Retarded Children 227
Arthur Mandelbaum

Some Observations About Mentally Retarded Adolescents 233
Arthur Segal

Extending a Hand to Parents of Disturbed Children 238
Joyce Edward

book notes 244

here and there 245

readers' exchange 247

An adopting couple and their "new baby" regard each other with delight and curiosity. The joy of finally receiving a child often obscures the anxiety such couples may feel about the special problems of being adoptive parents. How one agency is helping groups of such new parents help each other face some of the problems they are concerned about is described on pages 223–226.

children

National Advisers to CHILDREN

William E. Brown, *dentistry*
Alex Elson, *law*
Patricia G. Morisey, *social work*
Edwin M. Gold, *obstetrics*
Herman R. Goldberg, *education*
Beatrice Goodwin, *nursing*
Dale B. Harris, *psychology*
Robert J. Havighurst, *youth development*
Robert B. Kugel, *pediatrics*
Hylan Lewis, *sociology*
Winford Oliphant, *child welfare*
Milton G. Rector, *corrections*
R. Gerald Rice, *maternal and child health*
Albert J. Solnit, *psychiatry*
Franklin M. Zweig, *community planning*

Children's Bureau Staff Advisers

Hester B. Curtis, *chairman*
Division of International Cooperation

Grace M. Angle
Office of the Chief

Dorothy E. Bradbury
Division of Reports

Kenneth S. Carpenter
Division of Juvenile Delinquency Service

Hyman Goldstein
Division of Research

Jane S. Lin-Fu
Division of Health Services

Will Wolstein
Division of Social Services

Editorial Staff

Kathryn Close, *Editor*
Catherine P. Williams, *Associate Editor*
Mary E. Robinson, Willamena Samuels, *Assistants*

for those who would help young children build a foundation for later learning, a psychologist describes the . . .

Many doctors and psychologists used to believe that the young infant was so busy feeding and sleeping that not much learning went on; they thought that his development came about almost entirely as a result of his physical maturation. By contrast, recent child development research and observation of both well-stimulated and deprived children provide a basis for far more respect for the spontaneous ways in which the infant learns about himself and about the world and how he can function in it. In one article, I cannot review all the data and theory relevant to infant learning. I will, however, sketch some of the ways in which the relatively unorganized, passive newborn infant becomes the much more organized, curious, competent 2-year-old who copes ingeniously with many problems.

By the time the child is 2, he has learned to adapt his body, his needs, and his wants to the readymade schedules, demands, and opportunities of the world; he has also learned the value of protest, of fending off excessive pressures, and of wooing the response of adults. He continues to master a wide range of motor, cognitive, language, and social skills in the next 3 years before engaging in the formal learning process provided by school.

Discussions of the learning processes in a child have generally taken their departure from, or have been carried on in, the context of learning in school through formal lessons and drill. The thrust toward activity initiated by John Dewey's dynamic ideas did not evoke a comprehensive study of the range of spontaneous learning processes that go on in the first years of life in children growing up in stimulating and responsive environments. Piaget's studies of in-

SPONTANEOUS WAYS OF LEARNING IN YOUNG CHILDREN

LOIS B. MURPHY

fants [1] added to the recognition of the role of certain aspects of sensory-motor and cognitive learning but left many gaps.

The following list of some first steps in learning is based upon my observations of children in different settings and conditions of life in various parts of the world, as well as on results of research.

1. ***Learning to use reflex equipment*** more efficiently. The newborn infant's effort to perfect his sucking ability points to one of the first types of learning. Some babies are inefficient at first and have to practice to achieve skill, an effort quickly rewarded by more satisfying intake of milk. The improvement of feeding reflexes, including sucking, chomping, and chewing, is paralleled by effective integration of the internal digestive functions.

The Gestalt principle of closure [2]—the tendency of each functional system to become more orderly as a result of growth or practice, or both—is involved at all stages. The pleasure principle is probably also involved insofar as improved functioning eliminates the pain of frustration, delay, conflict, and ineptitude and results in "function pleasure"—pleasure in the well-functioning activity itself. The achievement of smooth and satisfying organic functioning provides basic conditions helpful to orderly cognitive learning.[3] This probably involves the equilibration processes discussed by Piaget.[1]

2. ***Passive looking, listening.*** Young infants can often be observed within the first days of life staring, listening, attending to a sight (bright light) or sound that impinges upon their senses. They may not actively reach out for stimulation until they have experienced some satisfaction from their first passive learning.

The first step is orientation.[4] Just as sucking and other oral patterns have to be refined, so does the coordination of external and internal eye muscles have to be improved with practice. But the baby begins to stare and to look almost from birth.[5] As a result, he learns to connect things seen together and, later, to compare and test.

3. ***Learning to actively select and turn toward stimuli follows*** upon reflex orientation. We can see this in some very young infants whose mothers respond to their indications of restless "wanting to see more." A 4-week-old infant in the group studied by Escalona and Leitch "couldn't be held lying down." [6] I, too, have held babies who were not relaxed until held in a position from which they could see around.

The baby's turning toward new patterns or toward particular colors or faces, well documented in research,[7, 8] is a step beyond passive looking at whatever is there. We often see very young babies in their mother's or father's arms visually exploring a strange environment. I have seen older babies, of 8 months to a year, twist and turn to maximize their visual range as they looked ahead, behind, to each side, and up and down. This visual searching probably leaves traces, or engrams, which in turn lead to fresh movements of the eyes as if to keep on catching still more. Berlyne [9] and others have discussed the intrinsic need for *fresh* stimulation, a need flagrantly disregarded in much institutional care.

People are observed more vigorously and often

than things by many babies, probably because some people provide gratification of their needs and also because faces and bodies are complex rather than simple, are constantly moving, and provide multisensory rather than unisensory stimulation. Pleasure derived from colors, shapes, and voices is also behind the baby's people-watching.

4. ***Exploration of a wider environment*** as the baby grows older and is able to move around, "casing the joint" and peering into things, is a still more active way in which infants and small children successively "find out about" the world and its possibilities. This very active, self-initiated effort to learn about everything around them can be observed in infants and children growing up in interesting and varied environments. But it is usually lacking in children growing up in barren, dull environments. The baby has to learn that active attempts to learn are rewarding.

5. ***Cognitive mapmaking*** as described by Tolman [10] is another aspect of learning in infants. The baby uses the results of his active exploring, organizes them, and holds onto them as an aid in orientating himself to the world, managing it, and getting around in it. The creeping baby soon learns that he can find mother in the kitchen even though he does not know the word for kitchen.

The baby learns by listening as well as through visual-motor and tactual activities. One 4-month-old baby I knew learned to recognize the sound of her father's footsteps and bounced in her carriage vigorously when she heard him coming. Some infants learn to recognize musical pieces and have favorites before they are a year old. Babies in our longitudinal research sample at the Menninger Foundation in Topeka, Kans., showed wide individual differences in their responses to different kinds of sounds. Some babies seem to make an "auditory map" along with a visual map of their surroundings—that is, they learn to associate certain sounds with places and actions.

6. ***Combining,*** bringing two things together accidentally or intentionally, helps the child to *discover what happens*—what sound results, for instance, if he bangs a wooden spoon against his crib. This results in the baby's "learning to make something happen," as Thorndike put it long ago, tying it in with the baby's "pleasure in being a cause." [11] Today we think of the dynamics of elementary feedback and the enhancement of self-awareness and of power as implied in Charlotte Bühler's observation of the "triumphierender Blick" of the nearly 1-year-old baby.[12]

Perhaps taking apart or opening up is also a form of experimenting to see what can be done with things. This type of activity begins with some babies at about the same time as combining. Pulling at things and tearing up paper, wool, or cotton batting contribute to the baby's learning about textures and the variously yielding or resistant qualities of materials.

7. ***Organizing*** all of the oral, auditory, visual, tactual, and visual-motor processes of learning goes on at different levels of complexity. Bits of raw stimuli become familiar and are organized into meaningful, complex units of experience and built into transactional structures, that is, internal patterns that become automatically available in a relevant situation. The overall pattern of such structures may be seen as the infant's "primary adaptational style." [13] One baby's style is very different from that of another. But these structures are not static and fixed. As the baby continues to learn more, he modifies his cognitive map, his coping skill, his self-image, and his relation with others—and this modification increasingly contributes to how and what he learns. More efficient structures displace the early, less inefficient ones.

We can see from the way a child as young as 2 or 3 years spontaneously organizes toys presented to him in a random fashion that the tendency to give structure to scattered materials is part of the human package of potentials [14] and gives the child what Berlyne calls "epistemic" curiosity.[9] The child's ability to structure depends on the degree of his previous assimilation of and accommodation to many kinds of forms and structures in the environment.

8. ***Mastery of the body,*** as in rolling over or holding up the head, exemplifies the same principles as the improvement of the functional reflexes, but includes an integrative quality not present in the reflexes. Body mastery is involved in the development of "ego functioning" in the psychoanalytic sense—that is, perfecting the motor skill is paralleled by, or followed by, use of the skill in an ego-controlled, or purposeful, bodily activity.

Learning to make oneself comfortable may take place at the same time. In the Escalona-Leitch sample, a 1-month-old infant wiggled herself to a cozy corner of her crib and stayed there.[6] Wiggling and turning the body around a little can often be observed in an infant before he is able to turn over from back to front or vice versa. By the age of 3 or

4 months, babies have learned to stretch, push, turn, or otherwise adjust their bodies when held. Turning away from unpleasant stimuli by turning the face or body away may be seen in even younger infants. This is one early way of adapting to the world.

9. ***Learning more complex body and motor skills*** continues steadily from early infancy. Learning to pull oneself up when somebody is holding one's hands, to turn over, sit up, creep, stand, walk holding on, and walk alone are steps that occur with practice as muscles achieve the necessary degree of coordination.

Each level of body management brings new learning possibilities. The baby may learn to cooperate in various kinds of gymnastic play with his body, initiated by his mother or father, and may bounce to rhythm when sung to. Such activities may involve learning to balance in order to maintain equilibrium while participating. For example, a 4-month-old baby I knew spontaneously learned to spread out her arms and legs to balance herself while her father held her aloft, supporting her abdomen on the palm of his hand.

Increasingly, the baby is able to use his improved motor skills to cope with restlessness and boredom or to satisfy his expanding interests. He may learn that, by himself, he can slide down his high chair and slip free of it or climb out of his crib. He may learn to creep downstairs backward before he can manage to go down forward.

All of these forms of body-learning not only develop increased flexibility in the baby, they also prepare the baby for learning more complex skills as he grows older.

10. ***The development of curiosity.*** Progress through the early stages of sensory and motor learning develops resources that contribute to further learning. Growing up in a richly rewarding, varied environment leads to an interest in further scanning and exploring. This is made possible by the extension of the range of motor skills that enable the baby to get into everything from the floor-level kitchen cupboards to the bottom drawers of his mother's dresser. Thus, he develops curiosity from the gratifying discoveries made in his widening world. The child deprived of stimulation usually does not show such curiosity.

We can say with Bateson [15] that through all the first phases of learning the adequately stimulated baby accomplishes important secondary or "deutero-learning"—that is, he learns to learn, learns that it

Following a normal developmental pattern, this happy infant has learned to select and turn toward stimuli. Apparently, the activities of the photographer interested him more than the toy.

is fun, interesting, and exciting to learn. The preschool children in our Topeka sample of middle-class children from at least moderately rewarding homes typically explored each new situation with eagerness, curiosity, and interest. In contrast, the children from disadvantaged homes did not do such exploring until after many months of encouragement and stimulation. Even then, they did not ask questions with the same degree of curiosity as the middle-class children. When the deprived children began to ask "why" questions, they asked chiefly about the teachers they had learned to trust, not about the world at large.

Thus, *learning to want to learn*, to respond to new situations with interest rather than passively or inertly or fearsomely, is another aspect of the early development of learning. This includes *learning to practice*, which may actually begin when the infant first "works at" improving his sucking and, later, other motor patterns. But the baby's spontaneous practicing becomes more conspicuous as he repeats syllables or assiduously struggles to master a motor skill.

11. ***Learning from pain.*** Many observers, including the mothers of children in our Topeka sample, have reported instances of very young children learning from pain. The child learns not to put his hand on a hot radiator after one painful trial. The cat scratches and *maybe* the child does not pull his tail

again. Levy,[16] in a study of 2,000 infants given a series of inoculations, found that after the first inoculation infants under 6 months cried at the total situation, including the office and the doctor in a white coat; the youngest infant who cried only at the approach of the needle was 6 months old. This implies development of the ability to differentiate a specific pain-producing stimulus from the whole context in which the pain was experienced. However, *learning to avoid* unpleasant immediate stimuli begins almost from birth.

While the baby searches and reaches out for stimulation, he also has to protect himself from overstimulation. Benjamin [17] has observed that the baby between 4 and 8 weeks old becomes more sensitive to visual and other kinds of stimuli. While the perceptive mother helps protect him, he also learns to protect himself by various methods of avoidance or protest. Infants 4 weeks old or younger have been observed to shut their eyes or turn their heads away from bright lights.[18]

12. ***Learning what to enjoy*** is similar to learning from pain. The youngest baby spits out bitter tastes and accepts sweet tastes. By the age of 4 or 5 months he smiles or reaches for pleasurable stimuli. At this age the babies in our Topeka sample had already developed preferences among foods, colors, toys, and other objects. Babies have subtly different preferences—some of them enjoy a rapid, vigorous rhythm while others prefer a slower, gentler one. Some enjoy longer and more intensive tactile stimulation than others can tolerate. As they grow, they acquire new tastes, that is, they learn to like things they did not originally like.

13. ***Learning to evoke rewards*** is related to learning to love. When a baby repeats such syllables as "da-da" or "ma-ma," he gets delighted smiles and hugs from responsive adults. Learning to evoke pleasant experiences is similar. At 20 weeks, one of the babies in our sample would bounce or rock on his mother's lap in order to stimulate her to bounce him in response. The mother's gratifying response in such a situation is part of the conditioning that goes on through much of early childhood.

Another infant at the age of 8 months would make a blowing sound with his mouth in order to get an adult to put a record on the phonograph; he was accustomed to seeing his mother blow the dust off a record before playing it. The baby always smiled in pleasure at the music or moved rhythmically.

The baby's social learning does not begin with his smile, but is accelerated by it, since the smile provides stimulating feedback from the mother and other persons. While the smile itself is an "innate" response released by sensory stimuli of various kinds [6] and by seeing the smile of another person or simply his eyes and forehead, the baby has to learn what his smile can do for him and how it brings forth attention and satisfying stimulation.

Loving is a complex outcome of much learning. Out of the early tactile and kinaesthetic experiences of being cuddled and exchanging smiles, the baby learns to love and be loved.[19] This mutual process gives rise to the learning of many patterns of expression in a more complex manner than the earliest conditioned responses are acquired.

14. ***Trial-and-error approaches*** to learning grow out of the child's accumulation of sensory learning, development of motor skills, evoked curiosity, and pleasure in making things happen. For example, a year-old baby will try this way and that to fit a cap onto a bottle or to put something into something else.

15. ***Learning through contagion*** has been noted in babies by both Escalona [20] and Anna Freud.[21] This tendency is related to a baby's anxious, tense response to a tense mother. In such situations, the baby may be learning through skin and muscle sensations as well as from facial expressions. Long ago Preyer reported on a very young baby's *ability to imitate* a protruding tongue although he cannot see his own tongue.[22] This type of learning, still an obscure process, may be related to the process of learning by contagion.

16. ***Learning by participation*** takes place when the mother plays with the child, for example, showing a 9-month-old baby how to play pat-a-cake by holding and moving his hands. All of the early mutual body adjustments between mother and infant have prepared the way for this. Older children also learn in this way. I have seen tiny newcomers to Israel helped at an induction center to learn to feel at home, to develop a sense of belonging, and to acquire some of the language through participating in singing and marching games, with adults taking them by the hand and leading them through the movements. Many children who find it hard to enter a new situation can be helped in this way.

17. ***Learning by imitation*** involves the use of skill in observation and interest in and responsiveness to new activities. A simple form is parroting. This type of response shows the essential humanness of the

learning processes since it involves not only sensory, motor, and perceptual learning, but also, probably, as Piaget has noted, the assimilation of the mother's actions and accommodation to them.[1]

18. ***Learning by identification*** is a more comprehensive and deeper kind of learning. It includes imitation, but it also includes a feeling with, an adoption of role, a fantasy of being the mother or father, and serves as rehearsal for taking on the real role in later life. Identification requires the capacity for organizing sequences. It was reflected in the behavior sequences of an 18-month-old toddler I observed who busied herself wrapping up her "baby" (doll), putting it into bed, covering it up, and saying "Night-night," while her mother cared for the new baby in an adjoining room.

19. ***Learning to cope with frustration*** usually involves some combination of *learning to delay gratification* until a later time, *learning to accept substitutes* for the specific object desired, and *learning to shift interests*. Some infants and young children learn to deal with frustration more easily than others.

Even when only a few weeks old, some infants who at first frown, cry, or turn away when a bottle is offered them instead of the breast finally learn to accept it. In our Topeka sample, most mothers consciously tried to help their babies *learn to adapt* to the nuisances of infant life by tempering the discomfort with soothing pats or cuddling.

In helping babies *learn to "get used to" new situations* and experiences, mothers also use conditioning methods. The alert mother helps the baby by providing opportunities to associate the new experience with familiar types of gratification, or by presenting the thing that is new to the baby, such as an unfamiliar food, in small amounts until he learns to like it. When a child responded to a rabbit with fear, Mary C. Jones [23] gradually reconditioned his response. In a series of stages, she brought the rabbit into the room where the child was happily eating, until he finally learned to accept it.

20. ***Learning to be comforted,*** to accept soothing from others, may depend on the skill of the mothering person in finding the soothing technique that is most relaxing to the infant. (Some babies may be soothed by jouncing or patting, but others will only become more annoyed by such treatment.) A corollary to this is the *expectation* that one can be comforted—the baby learns that hurts need not last very long and that he can evoke comfort from someone else.

21. ***Learning to amuse oneself*** is not the same as the simple process of learning to make something happen. It depends rather on the "deutero-learning" that when one is alone one can still engage in some satisfying activities. Finding this out, the baby then learns to initiate such activities.

22. ***Learning to fear.*** The capacity to be afraid and anxious is inborn, but the baby learns *what* to fear in the same way he learns to avoid pain. He may even *learn how afraid he must be in order to evoke support* from someone.

Fear of strangeness may be innate; strong negative reactions to strangers have been seen even in chickens.[24] But the fact that different babies show fear of strangeness and strangers at such varying ages as 8 weeks and 8 months shows that fear of the stranger is also related to how much the baby has learned to differentiate between the familiar and the strange and also whether he has previously experienced discomfort with strangers (in contrast with the comfort he associates with mother).[13]

23. ***Learning anger.*** The newborn's screams of hunger and pain sound so angry that we may think of anger as the first strong emotion expressed. It is evident before any expression of pleasure. But the baby learns rapidly what his angry protests will do for him. They are at first vocal, then physical: He learns to slap or hit, to stiffen or rear back, and to combine various other bodily behavior patterns in angry resistance. Breath-holding, head-banging, smearing feces, and other types of behavior may be included in the range of resources he learns to use in order to get attention or to make the adult stop doing something he finds unpleasant.

Any of these behavior patterns may arise spontaneously at first and then be quickly reinforced by

---

A psychologist who has concentrated on studying the personality development of children, Lois B. Murphy is director of the division of developmental studies at the Menninger Foundation, Topeka, Kans. She is also senior consultant to the infancy project being conducted by the Children's Hospital of the District of Columbia. Among Dr. Murphy's many publications is "The Widening World of Childhood: Paths Toward Mastery" (Basic Books, 1962).

the consequences, including the sensations they give the baby himself. (Some babies are careful not to hurt themselves when banging their heads against the wall or floor.) Pathological uses of such behavior patterns sometimes develop, especially in neglected babies, arising from a combination of self-gratification and masochistic enjoyment of pain. More normally, a baby learns to use such behavior as an effective method of *discharging* angry feelings and "getting over it fast."

24. ***Learning to trust the world,*** as derived from the basic relationship of mother and child, has been emphasized by Erikson.[25] The balance of trust and distrust of the world is also a global form of "deutero-learning" growing out of everything the baby has previously learned. The predominantly distrustful child will later learn chiefly those things that relate to danger and are perceived by him through vigilant, anxious, rather than open, eager observation.

25. ***Learning to unlearn,*** to give up old patterns, is a major learning process of infancy and early childhood. Giving up the bottle as new feeding methods are mastered, giving up creeping as one learns to walk, giving up babbling as one learns to talk, and giving up crying as one learns to express wants verbally are only a few of the important examples of learning to outgrow early forms of behavior. Sometimes, as when the child gives up creeping for walking, the principle of dominance supported by improved efficiency makes the giving-up easy; sometimes, as with weaning, the giving-up process has to be assisted by the mother using the pleasure and pain technique.

Outgrowing babyishness brings new rewards, among which is an expanded horizon for learning; for satisfying the sensory, motor, and manipulative urges, curiosity, eagerness for mastering the environment, and the wish for autonomy.

---

[1] Piaget, J.: The origins of intelligence in children. International Universities Press, New York. 1952.

[2] Koffka, K.: Principles of Gestalt psychology. Harcourt, Brace & Co., New York. 1935.

[3] Murphy, L. B.: Preventive implications of development in the preschool years. *In* Prevention of mental disorders in children: initial exploration. (G. Caplan, ed.) Basic Books, New York. 1961.

[4] Sokolov, Y. N.: Perception and the conditioned reflex. Pergamon Press, New York. 1963.

[5] Wolff, P. H.: The causes, controls, and organization of behavior in the neonate. *Psychological Issues,* vol. 5, no. 1, 1966. (Monograph no. 17.)

[6] Escalona, S.; Leitch, M.: Unpublished records of infant behavior at the Menninger Foundation, Topeka, Kans.

[7] Franz, R. L.: Pattern vision in young infants. *Psychological Record,* April 1958.

[8] Berlyne, D. E.: The influence of complexity and novelty in visual figures on orienting responses. *Journal of Experimental Psychology,* March 1958.

[9] ———: Conflict, arousal and curiosity. McGraw-Hill, New York. 1960.

[10] Tolman, E. C.: Cognitive maps in rats and men. *In* Behavior and psychological man. University of California Press, Berkeley. 1958.

[11] Thorndike, E. L.: The original nature of man. *In* Educational psychology (vol. I). Teachers College, Columbia University, New York. 1913–14.

[12] Bühler, C.: The first year of life. John Day Co., New York. 1930.

[13] Murphy, L. B.; Moriarty, A. E.; Raine, W.: Development and adaptation. To be published by Jossey-Bass, Inc., San Francisco, Calif., in 1968.

[14] Murphy, L. B.: Personality in young children. Basic Books, New York. 1956.

[15] Bateson, G.: Naven. Stanford University Press, Stanford, Calif. 1958.

[16] Levy, D. M.: The infant's earliest memory of inoculation. *Journal of Genetic Psychology,* March 1960.

[17] Benjamin, J. D.: The innate and the experiential in development. Lecture to the Topeka Psychoanalytic Society, Topeka, Kans., Jan. 26, 1961.

[18] Heider, G. M.: Vulnerability in infants and young children: a pilot study. *Genetic Psychology Monographs,* February 1966.

[19] Murphy, L. B.: Some aspects of the first relationship. *International Journal of Psychoanalysis,* vol. 45, pt. 1, 1964.

[20] Escalona, S.: Emotional development in the first year of life. *In* Problems of infancy and childhood. (M. J. E. Senn, ed.) Josiah Macy, Jr., Foundation, New York. 1953.

[21] Freud, A.: Comments in a case conference at the Menninger Foundation, Topeka, Kans. September 1962.

[22] Preyer, W.: Die seele des kindes. Leipzig, Fernan. 1882.

[23] Jones, M. C.: The elimination of children's fears. *Journal of Experimental Psychology,* October 1924.

[24] Levy, D. M.: The strange hen. *American Journal of Orthopsychiatry,* April 1950.

[25] Erikson, E. H.: Childhood and society. W. W. Norton & Co., New York. 1964. (Revised edition.)

PATTERNS OF CHANGE in DISTURBED BLIND CHILDREN in RESIDENTIAL TREATMENT

JOHN R. ROSS, JR., M.D. • BERNARD B. BRAEN • RUTH CHAPUT

About 4 years ago, the authors of this paper, charged with the task of rehabilitating an institutionalized group of 20 severely disturbed blind children, ranging in age from 6 to 12 years, began to formulate and test hypotheses about the factors impeding the development of these children and the methods by which they could be psychologically rehabilitated. We assumed that because of their blindness the children had from infancy been deprived of the stimuli necessary for development and the experiences that lead to a mutually satisfying mother-child relationship and that such deprivation had led to the deviations we observed in all aspects of ego functioning—in intellectual achievement, emotional stability, physical competence, ability to engage in satisfying interpersonal relationships. In some instances, the deviations had already been aggravated by congenital defects affecting the central nervous system.

On the basis of this hypothesis, we assumed that experiences could now be provided that, if appropriately matched to the developmental levels of the child, would provide him with more effective methods of adaptation than he had previously adopted and would thus facilitate more normal development. We, therefore, have concentrated our efforts on carrying out an educational therapeutic program that would provide such experiences and will here describe some of the changes that have taken place in the children. The institution that has been involved is the Children's Division of the Syracuse Psychiatric Hospital, located in Fairmount, a suburb of Syracuse, N.Y. Thus far, all the children in this residential unit have been blind children, though plans are now underway to accept other children. The staff has consisted of a child psychiatrist, a clinical child psychologist, a supervising psychiatric nurse, a staff nurse, a recreation director, four special education teachers, a psychiatric social worker, an occupational therapist, and several previously untrained child-care workers.

The children

The children were admitted to the program over a 2-year period, beginning 4½ years ago. Thus, we have known all of them for more than 2 years and many of them for more than 4. When admitted most of them appeared to be functioning at a severely retarded level; in fact, the parents of several of them had been told they *were* retarded. However, after the children had been with us for some time and had developed trust in the staff, manifestations of their intellectual capacity became evident and we realized that most of them were of at least average intelligence and many were very bright. Because of technical difficulties, previous testing of them had been misleading.

The impression of severe retardation was augmented by several behavior patterns, some of which seem to be characteristic of blind children. There was a great deal of rhythmic rocking, head rolling, body rolling, head banging, and whirling. Fingers or fists were constantly being stuck in eyes. Language was almost always used in private ways incomprehensible to members of the staff or other persons. There was

meaningless parroting of television commercials, phonograph records, or statements the children had heard people make. Pronouns, when used, were often reversed; "I" was never used. Mutism with occasional guttural sounds was frequent. Thus, the children isolated themselves from both peers and adult staff.

Among other characteristics were suspicion, hostility, fright, withdrawal, and extreme negativism. The most ordinary experiences would be regarded as terrifying. Though many of the children had learned the necessary skills for self-help, they retreated into helpless dependency.

Very few of the children had developed any skill in moving about; most of them released their motor energy while remaining almost in the same spot by using rhythmic or whirling movements. Some tended to overbreathe when excited, and some vented their feelings through screaming, scratching, and biting. Two or three retained feces; one had developed an enlarged colon as a result.

None of the children had had any successful school experiences. Two or three had learned a little braille, but none had been able to profit in any consistent manner from a planned and sequential educational process. Those who had been to school had been dropped out and the others had either remained at home or had been sent to institutions for the retarded or mentally ill.

When we encountered the children, their interest in the external world and in learning seemed nonexistent. Their attention span was short, and their frustration tolerance was extremely low.

The program

The heart of the program lay in an expectation that each staff member would show the same respect to each child regardless of his individual developmental level; would provide the child with interpersonal and other kinds of experiences to help guide him to the next step in development; and would patiently allow him to achieve that step at a speed consistent with his specific needs.

Such impartial respect was not easy to achieve. Many of the children developed subtle and skillful methods of attracting the staff's attention not only to meet their own needs but also to find out whether they could render staff members less effective in treating some children than others. Other children, because of their silence and self-effacement, made it easy for the staff to forget about them. Nevertheless, all the children were enormously sensitive to any degree of difference in a staff member's attitudes toward particular children. They obviously felt far more secure when they knew appropriate care was being provided equally for all. In spite of the difficulties, the staff did achieve a high degree of impartial respect, and this, more than any other element in the program, may have helped the children realize that they were free to experiment with many forms of behavior in search for paths to identity and development.

The program has also placed emphasis on continuing the children's relationship with their parents, largely through weekend visiting. Most of the children have gone home almost every weekend since their admission. This has meant that they have continuously had to adapt to the contrasting personal environments of home and hospital. The psychiatric nurse, the psychiatrist, and the psychiatric social worker have also maintained contacts with the parents, usually informally but occasionally in formal appointments, at their own or the parents' request. Some changes in attitude have occurred in many of the parents, especially as they have come to recognize that their children are not retarded. But, on the whole, the parents have not altered their basic rejection of the children and continue to wish for a child that is "normal" in every respect.

Some of the children have learned to perceive their parents' rejection of them without having to give up an emerging sense of identity in favor of utter compliance and without having to accept the idea that they are peculiar and incompetent. With the help of the psychiatrist and selected staff members, they have been working through feelings of extreme anger toward their parents, anxiety about such anger, and an increasing sense of separation from them accompanied by intense grief. A few have emerged from this emotional struggle with greater tolerance for their parents and greater confidence in their ability to adapt to them. None of the children, however, has actually completed this working-through process.

One aspect of the program that has helped to decrease anxiety in the children has been the provision by the psychiatrist of all medical care and supervision, except in instances of severe illness or injury.

John R. Ross, Jr., M.D., and **Bernard B. Braen, Ph. D.,** are professor and associate professor, respectively, in the Division of Child Psychiatry, Upstate Medical Center, State University of New York, Syracuse. **Ruth Chaput** is the supervising psychiatric nurse in the Children's Division of the Syracuse Psychiatric Hospital, Fairmount, N.Y.

All the children at first were terrified of even painless medical procedures. As they became familiar with the psychiatrist through frequent contacts with him, they developed enough trust in him to accept, and in some instances even to participate actively in, medical procedures, including the physical examinations carried out by him. This led to some children learning to cooperate readily with the dentist and with the pediatrician when he is called in.

Regression and progress

In spite of careful preadmission preparation, the children always reacted to admission with a great deal of separation anxiety and grief, which each revealed in his own way. Some children on admission wept quietly, withdrew completely, behaved frantically, or talked constantly about gratifying experiences they had once had. None attempted to cling to staff members for comfort.

Members of the staff could do little at this time other than to tell the children about the care they would receive and when they could next be with their parents and to help them with the daily tasks of bathing, washing, toileting, dressing, and eating. No physical examinations were attempted.

After admission (shortly afterward or long afterward) some regression occurred in most of the children and was accepted by the staff. Many of the children gave up skills they had painfully acquired over years of home training. They ate with their fingers, refused to eat altogether, or demanded special foods. They refused to wash, bathe, or dress themselves, although nearly all had performed these tasks with skill before admission. Many of them began wetting and soiling themselves, although they had not been doing this previously.

Psychological testing was, of course, impossible in this period, as was group or individual psychotherapy in the usual sense. As in the admission period, the attempt to establish meaningful relationships was made through giving the children practical help in the daily tasks of living such as cutting up their food, serving and feeding them, bathing them, cleaning up their vomitus and feces, and making their beds. *All* staff members, professional and nonprofessional, participated in these tasks.

During their regressed phase, most of the children began exploring the environment, primarily by touching and listening. A child who seemed completely out of contact with reality, for example, would be found whispering something he had heard somebody say in person or on the radio or phonograph, minutes, hours, or days before. Some children would mimic staff members or other children without interacting with them in any other way. Some clapped, stamped, whistled, or clucked as they went about orienting themselves by sound or touch to their environment.

Very gradually, a few children began to evince an interest in having mutual relationships with people. Others only seemed to be "with" people; they initiated contacts, were compliant, and talked relevantly but their interaction was superficial and manipulative. Usually, a relationship was begun by a staff member making himself available to a child either to help him with a task such as dressing or to give him an experience such as going for a walk, swinging, jumping on the trampoline, or playing a record. The child would at first simply move closer, touch the adult, or talk in obscure phrases. Some children valiantly tried to comply with the adult's wish even when they did not want to participate in the suggested activity. Others responded negatively, obviously expecting reproach and punishment.

Some children who seemed to be relating with adults best because they knew how to talk intelligibly achieved the least genuine relationships. As time passed, they failed to progress past the stage of asking and reasking questions or talking about irrelevant and meaningless topics. Other children who at first seemed much less ready for human contact because they proceeded so cautiously eventually formed meaningful relationships both with staff members and other children.

After breaking through their isolation to make a contact with another person, the children would begin experimenting with others—at first, usually, only adults. They would gradually learn to distinguish between the roles of the various staff members and to relate differently to different persons, dependently with some and independently or even negatively with others. As they became more confident, they would usually attempt to manipulate adults by conversation, compliance, defiance, or negativism, and often mimicked the admonitions and reproaches they had received at home and thereby revealed much about their previous relationships. From such responses, the staff could begin to recognize the carefully concealed personalities of the children and their highly individual ways of looking at life and people.

At some time during the course of this experimenting with relationships, each child would begin to pay attention to other children and to the sur-

rounding environment. No child remained completely aloof and isolated; all formed relationships of some kind with several persons. But these relationships were developed by some children more rapidly than by others and were constantly changing. The children would identify first with one adult and then with another as though they were attempting to work out different ways of feeling, thinking, and being as they made their way toward less distorted conceptions of themselves. A whispered word, an interrupted gesture, a slight change in the verbal pattern heralded major changes to come. As the children grew self-confident because of many staff-planned experiences of success, they began to develop genuine respect for each other and to form strong friendships. Eventually they came to know each other very well and in some cases far better than the staff knew them. They were extraordinarily aware of each other's feelings and actions. They were tolerant of each other's behavior and often perceived the meaning behind it. Sometimes even when a child was attacked by another and his feelings deeply wounded, he could be objective about why the other child had behaved as he had. Gradually some children revealed themselves as followers and others as leaders; some as passive and submissive and others as active and dominating; some as quiet and others as noisy; some as given to intellectuality and others as given to intuitive responses; some as humorless and others as full of humor.

The struggle for a sense of identity met with obstacles, too. For example, Jane, a severely disorganized psychotic child, was made intensely anxious by an even more disorganized child, Mary Ann, and would immediately leave the room when she became aware that Mary Ann had entered. Whenever Mary Ann would scream, stamp, and bite herself, Jane would become panicky and burst into tears.

Use of language

The children's growing ability to relate to people and to identify their own individuality was revealed in their changing use of language. At first nearly all the children spoke to staff members only in meaningless phrases; they used language not to communicate but to conceal. But gradually, as they learned that the staff members could be trusted and were trying to understand them, many of the children learned to respond with some relevance and intelligibility, with less secretiveness, and with a more appropriate use of pronouns.

In their increasing interactions with each other, the children used language to mimic, ridicule, tease, manipulate, or simply to play with a kind of code that they all seemed to understand and to enjoy. Perhaps what they enjoyed most was the knowledge that *they* knew what they were talking about but the staff member in attendance did not.

The children's use of language has provided an instrument for measuring changes in self-concept and levels of anxiety. When we first knew them, most of the children referred to themselves by name, or by the pronouns "he" or "she" or "you." Some have gradually begun to say "I," although even those who have improved most still have only a tenuous hold on this self-identifying pronoun.

Reduced anxiety

As the children developed relationships with staff members and with other children, their anxiety notably decreased. They showed fewer signs of panic when introduced to new experiences or to strangers. Their reactions became less extreme and more controlled in expression. They began to exhibit defense mechanisms against anxiety. Perhaps the most important influence in reducing anxiety was their certainty that they would be dealt with candidly by the staff. Some children, in an effort to master their anxiety, began to talk constantly about situations that provoked anxiety in them. Some, when in anxiety-provoking situations, would talk about previous situations that had been comforting to them.

As the children's anxiety decreased, they reacted with less negativism, accepted limitations on their behavior, tolerated frustration better, and began voluntarily to explore the space around them. Since the unit is in an open building situated on spacious grounds and the children have been free to go in and out, opportunities for exploration have been extensive. A few of the children have explored the whole area thoroughly, and most of them have become well enough acquainted with it to be able to get about in it efficiently. They often go outside to seek privacy and so reduce the anxiety generated by increasing contacts with others.

Thus it is obvious that another respect in which the children have changed is mobility. Apparently, anxiety and fear of aggression had as much to do with the extremely constricted mobility they had shown on admission as did fear of injury or disorientation in space. While the whirling, rocking, and rhythmic movements have persisted in most of the

children, the frequency and intensity of this type of behavior have greatly decreased and the children's ability to move in a relaxed, coordinated fashion in play, exploration, or aggression has noticeably improved.

Other children have learned to roller skate and to dance. However, the motor experience in which the children seem to feel most free is swimming. They have been taken regularly to a nearby indoor pool in the winter and to a lake in the summer. Many of them rapidly lost all fear of the water and especially seemed to enjoy the three dimensional freedom of underwater swimming. However, they responded negatively to attempts to *teach* them to swim; they wanted to learn to manage the watery environment on their own or at least to control what the adults did with them in the water. Only after many months of exploring to find out what they could do by themselves were any children ready to learn to swim in the usual way.

Changes in aggression

As the children's anxiety decreased, so did their fear of aggression, their own and others'. When they first came to the unit, most of the children made attacks only on themselves—biting their arms, violently slapping their faces, or banging their heads against objects. At the same time, they were very much afraid of being attacked by someone else and usually would move rapidly away if anyone at all touched them. After a while, they began tentatively to attack objects—a toy or something metal that made lots of noise, like a window screen. Gradually they became destructive of things and eventually they began directing their aggression against staff members by scratching, pinching, biting, kicking, and hitting them. While the staff members often protected themselves by moving quickly out of range, they responded with equanimity, thus helping the children to feel safer in directing their aggression outward.

As the children developed relationships with other children, they learned to assert themselves aggressively with each other. They still try to control the anxiety they feel about their own aggressive actions by finding reasons why the other child "deserved it" or by setting up rules under which aggression might be expressed. Often the whole thing is turned into a game in which a child, known by the others to be very angry but completely incapable of showing it and unwilling to defend himself, is playfully attacked. Sometimes, rather than engaging in combat himself, a child will direct others to tease or attack the object of his anger. The children talk a lot about aggression and whether or not people who engage in it are "good" or "bad." At times a child will attempt to keep his feelings of aggression from getting out of his control by asking permission to pull someone's hair or bite him.

After a while the children's primitive, highly aggressive outbreaks began to decrease. They were replaced by more ritualized and controlled forms of aggression in some children and by a redirecting of energies into environmental exploration, program activities, and learning in others.

Limits and demands

As these developments have taken place, the staff has attempted to keep pace with the developmental needs of the children, providing new experiences of all kinds—physical, emotional, social, and intellectual—in an increasingly more controlled and directed program. For example, the children's participation in making or listening to music has increasingly been directed to specific ends.

Most of the children, before coming to the unit, had had extensive experience with record players. Some had had piano lessons and had learned to play well. However, the children's musical experiences often had been associated with some unpleasantness—being pacified or isolated or having an ability exploited to the neglect of important needs.

As the children began to show more interest in music, the staff began to impose limits both on phonograph playing and the use of the pianos. The music teacher made advance schedules for playing records or tapes and selected those to be played, exposing the children to a wide variety of music. The children now listen intently during the music period and are often heard spontaneously humming tunes from the music that has been presented to them. They have completely accepted the restrictions placed on their handling of the musical equipment.

As specific children indicated they were ready to learn, the teacher scheduled formal music lessons and practice periods for them. However, some of the children who asked for music lessons were denied this privilege because of indications that they would then have given up all efforts to develop in other ways, or because they were interested not in learning but in competing with other children.

The music teacher, like the rest of the staff, has been heavily involved in all aspects of the children's

development. He helps them make their beds, dress, and clean their rooms, and he goes on expeditions with them. The children have thus learned of his interest in their development as a whole and have acquired such confidence in him that they can accept teaching from him without having all of their negativism immediately aroused.

As the children have moved toward greater relatedness, an increasing complexity of performance has been demanded of them. The staff has shown its respect for their capacity to grow by insisting that those who are able to do so make their own beds, put away their own clothes, dress themselves, use table utensils, and assume such chores as setting the table, carrying their own dishes out to the kitchen, helping to serve food, and washing dishes. Such demands have not been made on all children simultaneously but only on specific children as they have shown readiness for assuming some responsibilities. Of course, there has been much resistance on the part of the children to such demands, but as they have carried out the tasks involved, their respect for themselves and for each other has appreciably increased. All the children are now actively participating to some degree in their own physical care, and a few are helping in the care of the more dependent ones.

Presently, about half of the original group are participating effectively in an educational curriculum including French, English, biology, history, braille, and music appreciation. Four are learning music theory in addition.

Contribution of the staff

The most important ingredient in bringing about the changes noted has been the willingness of staff members to work as a team, to see beyond their own specific professional identities to the ultimate importance of building in each child a capacity to trust and to relate to other people. This has meant that everybody on the staff has had to take part in meeting the child's particular needs of the moment, whether this involved cleaning up a mess, bathing, dressing, or feeding. It was only through giving the children such elemental forms of patient attention that they could help the children learn to trust.

At first, the staff had no comprehension of this fact and could not function as an integrated team. There was little agreement as to how the children should be treated or about the nature of their problems. There was much confusion and intrastaff hostility, particularly in relation to problems of professional identity and theories of child care. Some staff members left, unable to adapt at all to the team approach. Others adapted sufficiently for the staff to be gradually welded into a smoothly coordinated therapeutic team, adjusting flexibly to the changing developmental levels of the children, picking up and acting on cues from each other, and being mutually supportive in trying times. There have, of course, been some weak links, for to achieve an ideal coordination in working with such children is a difficult task.

We have found, however, that when a central core of professional persons retains responsibility for coordination and planning in relation to each child, the children can learn to adapt to those staff members who find themselves temporarily or permanently at odds with the team's generally accepting and encouraging approach. We have also found that the staff members who can be noncoercive and at the same time can encourage children to have new experiences are those who best avoid feelings of depression and inadequacy in themselves and are those most trusted by the children.

In the near future, the unit is to become the Fairmount Institute of the Division of Child Psychiatry of the State University of New York, Upstate Medical Center, Syracuse. It will be greatly expanded and will include sighted as well as blind children in both residential and day treatment.

. . . Increasing specialization of professions and agencies calls for increased skills and increased facilities in the coordination of services, and this *coordination* is dependent both on a willingness to *cooperate* and an ability to *communicate.* Here lies an ever-present challenge for all of us working on behalf of the world's children.

Gunnar Dybwad, director, Mental Retardation Project, International Union for Child Welfare, in a report to the Union's General Council, September 1966.

helping

ADOPTING COUPLES COME TO GRIPS WITH THEIR NEW PARENTAL ROLES

EDITH M. CHAPPELEAR

JOYCE E. FRIED

When a husband and wife learn that their application to adopt a child has been approved, it is for them as though their fondest dream has come true. But when the child is actually placed with them, questions that ought to have been resolved through the home study process may arise. However, their reluctance to share anxiety with a caseworker after placement often makes it difficult to help them prepare for the special problems they may face as parents of adopted children. The Montgomery County (Md.) Department of Public Welfare has found the group discussion method an effective way of breaking through such reluctance.

The agency has had professionally trained social workers on its adoption staff for the past 4 years. During this time it has emphasized the preparation of applicant couples during the home study for the problems they may face as adoptive parents.

Over the years, the agency found that the early period of placement is the most crucial to the quality of parent-child and child-parent adjustment. Unfortunately, it also found that this was the period when social workers face the greatest difficulty in finding a meaningful relationship with adopting parents. At this point, parents were usually most unwilling to discuss or come to grips in any way with the problems they might have with their children. The caseworkers felt effectively shut out by couples who had participated actively during the home study and preplacement period. For the adopting parents, once they had the baby, the focus seemed too narrow to include only themselves and the child. In talking with the caseworker, they tended to gloss over their problems and to make only platitudinous observations such as "It is as though he had been with us always."

Knowing that initial parent-child adjustment is rarely so idyllic, the adoption unit considered the following possible reasons for the failure to get a true picture of what was going on in these homes.

1. The worker's visits in the supervisory period seemed threatening to adoptive parents. The couples felt that since the agency still retained guardianship over the child it might use its authority to remove the child if the social worker thought the placement was not proceeding satisfactorily. Parents, therefore, felt a great need to emphasize the positive.

2. The couples unconsciously felt that discussion of the strangeness, fears, and changes involved in the new experience of adoptive parenthood would sharpen their awareness of the differences between adoptive and natural parenthood. They preferred to avoid the pain of speaking of something they would like not to exist. It is easier to deny an unpleasant fact than to face it, particularly in talking to a person vested with authority.

Realizing that both these reasons were probably operating to a certain extent, we wondered whether the parents might be able to help one another. We, therefore, instigated the program of group meetings to supplement the social workers' individual interviews with the parents. Under the plan each couple was to attend two group meetings in the office in the supervisory period: one, 6 weeks to 2 months after the placement, and the other, 1 week after that. One home visit was made by the caseworker within 2 weeks after placement.

The new program got underway in October 1965. Each meeting was attended by five or six couples and lasted about an hour and a half. Discussion was led by a caseworker, who encouraged the couples to participate and gradually turned the meeting over to them as much as possible, intervening only with occasional guidance. No two meetings were exactly alike. They varied with the group's composition and the leader's experience in stimulating discussion.

The only bases for membership in specific groups were the date the couple had received a child and the age of the child. Parents who were adopting children over 4 years of age met in separate groups. Some couples were having their first experience with parenthood; some already had one or more adopted children; some had children who had been born to them in addition to one or more adopted children. The age range among the couples was wide: from the early twenties to the forties.

The only common denominator among the couples was the similar situation they were in: they had all undergone a home study and had a child placed in their home by an agency—usually the Montgomery County Department of Public Welfare, but sometimes an out-of-State agency for whom the department was carrying the supervisory responsibility.

The discussions were always concerned with the adjustment involved in becoming an adoptive parent, the kinds of problems that could be anticipated, and how they might be met.

The meetings

The first of the two meetings each couple attended was focused on the subject "Being Adoptive Parents"; the second, on "Being an Adopted Child." The discussions covered the following aspects of adoption:

1. The difference between adoptive and biological parenthood.

2. Helping a child to an acceptance and understanding of his adoptive status.

3. The adoptive parents' feelings toward the child's biological parents.

4. The adoptive parents' feelings about illegitimacy.

5. Letting persons outside the family know that the child has been adopted.

The group leader always opened the first of the two meetings by explaining the purpose of having them—giving the couples an opportunity to discuss a common experience and problems of common concern. She pointed out that the agency's workers were always ready to be of help, but that in a way they were on the outside looking in and that the agency believed the participants as new adoptive parents might have something to say to each other. In almost every group, the parents in their first meeting began to discuss questions their friends, relatives, and acquaintances had raised—questions they resented and did not know how to answer. Almost all had been asked what they knew of the child's background. To this, many of them had given angry, evasive answers such as "none of your business." Some had even been asked if they could really love an adopted child as they would a child of their own.

Both Edith M. Chappelear, left, and Joyce E. Fried were on the staff of the Montgomery County (Md.) Department of Public Welfare when they wrote this article, Mrs. Chappelear as adoption supervisor and Mrs. Fried as a caseworker in the adoption unit. Both have recently left the agency because of family responsibilities.

Often during the first meeting a parent would express concern about how his adopted child would look on him and whether the child would feel he had no need to respect or obey him because adoptive parents are not "real" parents. In discussing this possibility, the group members usually decided that it might happen, but then someone—sometimes the group leader, sometimes one of the parents—would point out that even children living with their "real" parents often had moments of rebellion, and examples would be cited of such children who had accused their parents of not being their "real parents."

The parents were nearly always unanimous in feeling that they would have difficulty in discussing the subject of adoption with their child. In the first meeting, the group leader did not usually make specific suggestions in regard to this problem but, rather, suggested that the parents think a lot about what they might do, read about what others had done, and plan to discuss the subject again in the second meeting.

The second meeting usually started with a reading of the minutes of the previous meeting after which the group leader would ask whether the participants had any questions they would like to discuss further. Often the first question raised was whether it is important to discuss the fact of adoption with the child. All of the parents had been encouraged to explore the subject in their individual interviews with the social worker before a child had been placed with them. The questions of "when" and "how" usually elicited much difference of opinion. In one group, for

example, a man who had adopted four children from different agencies said he felt he could tell them all that their parents were dead.

"To me," he said, "they are dead. If the children believe they are living they will go to the ends of the earth to find them."

His wife did not agree with him. Other couples said they understood his wish to "bury the parents" but tried to explain to him why this would not "work." They said that they could not in good conscience falsify the facts, that it would be easier for them to help a child face and accept the facts behind his placement than to live with a lie. Some parents said they felt that "truth will out" anyway, that as the child got older and learned more about the frequent association between illegitimacy and adoption, he would begin to wonder if his adoptive parents had been entirely truthful with him. All of the parents in the group indicated they felt they could not comfortably repeat an earlier falsification, nor did they wish to jeopardize their relationship with the child by admitting they had lied originally to protect him.

The group leader always encouraged the participants to talk about why it would be difficult for them to bring up the subject of adoption with their child. Usually it turned out that their difficulty was closely related to their feelings about the child's out-of-wedlock birth. As one participant expressed it: "It's hard enough to talk to a child about sex without having to talk about birth out of wedlock." Some parents tried to reassure themselves that out-of-wedlock birth would have no stigma by the time their children were old enough to ask questions.

The leader would then encourage the participants to discuss their feelings about illegitimacy in general, how these feelings were affecting their feeling about the natural mother of their child, and what other feelings they had about this "unknown" (as far as they were concerned) woman or girl. The reactions were as varied as the personalities of the participants. There was usually at least one parent who said the mother "didn't care" that she had "dumped the baby with the welfare." This was always countered by other with compassion—"She will always remember," "The birthday will be terrible for her," "She tried to give the baby what she couldn't give by herself—a family."

When the discussion revealed the parents' negative feelings about unmarried mothers and even some fear that their adopted children might become as "irresponsible" as the women who bore them, the group leader would ask the parents why they themselves had come to the agency and then would try to help them see that an unmarried mother who has released her baby to an agency for adoption has shown the same sort of responsible concern for the child's future as has the couple who has come to a social agency to secure a child for adoption. When the group leader asked what kind of information about the mother of their child might be helpful to them, the parents would usually respond that they did not want to know very much.

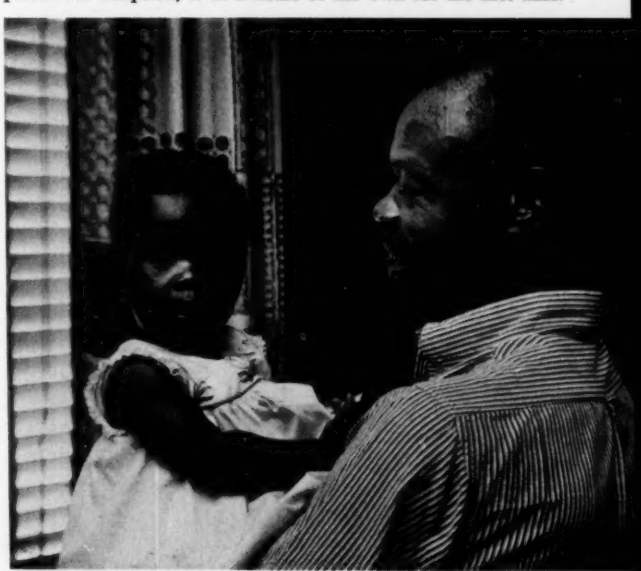
While the major part of both meetings was spent discussing the effects of adoption on the parent-child relationship, the group leader would always make a point of bringing the discussion around to the danger of overemphasizing the fact of adoption both in the parents' direct dealings with the child and in their search for causes of whatever behavior difficulties may arise.

The leader always closed the second meeting by expressing the agency's belief in the ability of adoptive families to become closely knit, loving families.

Because only two postplacement meetings were held with each group, we did not attempt to do anything more in these meetings than to raise questions and to help adoptive parents talk about them together so that they might become more comfortable in their new parental role.

After nine series of meetings, we sent a letter and

Alert to the wonders of a new environment, this little girl, just placed for adoption, is in a home of her own for the first time.



a questionnaire to the 44 couples who had attended them in an attempt to evaluate the program. The couples were not asked to sign the questionnaire. The letter explained that the meetings had grown out of the agency's desire to help the parents discuss problems of concern to all of them. Thirty of the couples filled out and returned the questionnaires.

Parents' opinions

The following is a list of the questions with a summary of the parents' responses:

1. We did (or did not) find the postplacement group meeting helpful—21, did; 7, did not; 2, "somewhat helpful."

2. Did the meeting evoke any new questions in your minds concerning adoption? If yes, what are they?—1, yes; 25, no; 4 returns showed no response to this question. A specific question was not mentioned.

3. Did you find the subject matter stimulating?—14, yes; repetitive?—5, yes; moderately interesting?—7, yes; not pertinent?—2, yes; a waste of time?—none; no response—2.

4. Did the questions raised cause you to worry? If yes, which ones?—1, yes; 28, no; 1, no response. (The respondent who answered "yes" did not explain.)

5. Please check which, if any, of the following subjects seemed appropriate to your present experience and worth talking over in a group: (*a*) Adjustments involved in becoming a parent—7; (*b*) difference between adoptive and biological parenthood—4; (*c*) helping a child to an acceptance and understanding of his adoptive status—23; (*d*) adoptive parents' feelings toward child's biological parents—5; (*e*) adoptive parents' feeling about illegitimacy—3; (*f*) sharing knowledge of child's adoption with outsiders—12.

6. Did you feel free to express your opinions and feelings at the meetings?—26, yes; 4, no response.

Twenty couples offered suggestions of topics they would like to discuss in future meetings. Most frequently mentioned was the desire to speak with a couple who had been adoptive parents for some time.

The four caseworkers who conducted the meetings regarded them as varying in their effectiveness. In some of the sessions, the discussion was very lively; in others, the leader was hard put to stimulate any kind of discussion. In general, we found that couples whose ages and family situations were analogous and whose adoptive children were of similar ages seemed to have more to say to each other than to couples whose family situations were markedly different from their own. We found, too, that the couples were often more interested in exchanging pictures of and pleasant anecdotes about their children than in thinking out loud about the problematic and emotional aspects of adoption. Several parents said at the meetings that the problems seemed "so far in the future" that they found it difficult to theorize about how they would meet them when and if they occurred.

Nevertheless, the answers to the questionnaire showed that 23 of the 30 responding couples found topic 5c—helping a child to an acceptance and understanding of his adoptive status—the most "appropriate to their present experience and worth talking over in a group." This, of course, is the crux of the problem.

What of the 14 couples who did not answer? Since we did not require the returns to be signed, we have no way of knowing who responded and who did not. Perhaps in some instances the questionnaire was not received because of changes of address. For the majority of those who did not respond, however, one or the other, or both, of the following assumptions may apply:

1. The couple was reluctant to indicate a negative response and, therefore, did not reply.

2. The child seems to have become so much a part of the adoptive family that the parents have not wanted to be reminded of the adoptive status.

In either case, it is difficult if not impossible to tell whether the meetings were of value to these couples.

Some of the agency's caseworkers who have not been directly involved in the group meetings have expressed some skepticism about their value. They have not relished the possibility of being exposed to criticism from a group of parents who by and large have resisted their efforts to be of service in individual interviews. The agency has, however, come to the conclusion that it is better to help adoptive parents in a group situation than in a one-to-one relationship. It is, therefore, continuing to carry on group meetings, and at the same time it is seeking ways to improve its service to adoptive parents through a combination of individual and group approaches.

THE GROUP PROCESS in helping PARENTS OF RETARDED CHILDREN

ARTHUR MANDELBAUM

When parents are confronted with the fact that their child is retarded, they often enter a period of mourning and grief, accompanied by emotional isolation and loneliness. They feel like exiled aliens in a world that has turned suddenly and unexpectedly cruel and harsh. Such loneliness, tinged with vague, obscure, and little understood feelings of guilt and shame, tends to lead to silence. Communication becomes unbearably difficult and isolation increases.

The human spirit, however, with its vast capacity for enduring stress, develops inner defenses and methods of dealing with sorrow. One human attribute is restlessness, a refusal to be content with the world as it seems. Parents of retarded children have a way to express their discontent, their wish for creative action, by joining together in an association of parents of retarded children. The purpose of such an association is to sustain and strengthen individual parents who are trying to handle similar problems and, thus, to halt the unbearable feelings of being alone and isolated. By thus joining together, parents not only meet important needs they have in common, but also use their collective strength to help their retarded children. They organize and build day-care facilities and training centers, urge the public schools to include special classes for retarded children, raise money for research, and persuade legislatures to pass laws aimed at improving State institutions.

All these efforts have salutary effects—the parents emerge from their isolation, and services for retarded children improve. But what of the parents' interior life, their inner feelings? As Bernard Cohen has noted "the stability of the interior environment is the condition of free life." [1] How can such troubled parents be helped to find inward stability and freedom?

One way found to be effective in helping such parents come to terms with themselves is to bring them together in small selected groups under the leadership of a professional person who can help them share common educational, social, and emotional experiences in a way beneficial to each member of the group.

The following analysis of the process that takes place in such groups is based on my experience as a social caseworker who has worked with several small groups of parents of retarded children in the past 7 years—some made up of mothers and fathers, some of mothers only. The groups met once a week for 1½ hours each session. Some groups ran for six sessions; some for 10 or 12 sessions; some, even longer. The members of the groups themselves determined how long they needed to continue meeting together.

The group process is used to help each member to bring forth his concern, anger, and thoughts so that gradually his strength comes to the fore and he can use it more creatively and independently in handling

Based on a paper presented at the 1967 meeting of the American Association on Mental Deficiency.

the social and emotional problems stemming from his child's retardation. If the group members can express both their positive and negative feelings and the leader is not critical, hostile, authoritative, or judgmental and is skillfully able to ease communication, then each can grow through the experience. As each member gradually gains more knowledge of himself and of the others in the group, he expresses himself with greater freedom and spontaneity. He learns his wife has feelings he did not know she had and had not recognized in himself. He also learns that she and others have feelings that he thought existed only in himself. He begins the difficult task of learning to listen to *others* talk about *their* feelings, not only to himself. He listens to ideas expressed in a continuous, evolving process and gradually becomes aware of the intense feelings behind them and of how little he knew of this before. He may then come to understand some of the sources of his own angry feelings and to sense that they are rooted in irrationality, disillusionment, and failure to realize his dreams.

Some themes

Perhaps the most significant aspect of a group process is the opportunity it gives the parent to further resolve his grief. This is necessary before the parent can release his capacity for profound understanding. As Solnit and Stark have said: "Coping with the outer reality of a child with a congenital defect and the inner reality of feeling the loss of a desired normal child requires a great deal of mental work. Such psychic work is slow and emotionally painful, and it proceeds through the gradual and repeated discharge of intense feelings and memories. These mental and emotional reactions enable the parent to recognize and adapt to the reality of the retarded child." [2]

In many young or comparatively young parents who have the major part of their lives still ahead, the trauma they experienced when they first learned of their child's mental defect remains a raw wound.

Mrs. A. spoke dramatically of a dream she had had several months before the birth of her child. In the dream she climbed up to a balcony and then dropped the baby over, shattering him to bits.

Several persons in the group gasped, and several other mothers said quickly that they too had had premonitions of disaster before the birth of their children.

Mrs. A. said that while she was pregnant she had seen a TV program concerning the mercy killing of a mongoloid baby. She recalled being greatly upset and thinking, "How dreadful if my baby would be like that." She described her feelings when she learned that her baby was "like that": "I was in shock, I couldn't believe it, I couldn't think."

Mrs. E. told of an experience her sister-in-law had had with an impersonal and busy doctor. His way of letting her know of her misfortune was to remark casually as he left her hospital room, "You have a retarded child."

A shocked silence followed. Mrs. F. said softly, "I imagine it must be hard for the doctors also."

After some moments of further discussion, the worker asked whether the parents thought it was hard for a doctor to tell parents they had a retarded child.

Mrs. G. said her doctor had tried to tell her a little every day about her baby's condition. She thought he was afraid she might not be able to take it. Finally one day she said to him, "For goodness' sake, tell me the truth." He did. Her husband, who already knew, brought her books on the subject. But that proved to be the wrong thing to do. Her husband meant well, but some of the books contained wrong information.

Mrs. B. said she also read books about retarded children; some of these books were sentimental and phony, but, "I did learn a little about the subject."

Mrs. C. shrugged, "I was in shock, but I got over it right away."

Mrs. G. laughed in a challenging, anxious, skeptical way. Mrs. C. insisted, "But I did. I realized it was not too bad to have a blind child because they can do many things for a blind child. I didn't know then he was also retarded."

Mrs. D. said that for a long time her doctor did not know about her child's condition because "doctors still don't know many things."

Mrs. G. described how hard it was for her to tell her mother about her child's condition. Tears came to her eyes as she related how both she and her mother wept. This led her to talk about how the child cried almost incessantly. She said she needed to keep faith in God.

Some parents express their fear of having more children and their envy of other parents:

Mrs. A. said that when she sees other couples having healthy babies, a pain hits her; she thinks she is jealous. Mrs. B. said she is jealous, too, but that she knows it is wrong to have such feelings.

The discussion then turned to parents who have normal children and complain about them or abuse them. The feeling that "they do not know how lucky they are" was expressed vehemently and often.

Some themes, common to all discussion groups of parents of retarded children, are introduced with insistent force early in the group process: feelings of isolation, of loneliness, and of inability to communicate with others are quickly recalled.

Many parents tell about how impossible they found it to speak to anyone after the shock of learning about their child's condition. It seemed to them then that there was no one available to listen, at least no one

capable of understanding. Professional people could not understand—they seemed, in a sense, like the parents themselves, human, fragile, fearful, lacking the courage to face the problem, to speak about it, to talk honestly, directly, and kindly. As outsiders, they could not *really* understand.

Then the parents begin gradually to bring up their feelings of anger and frustation, forbidden, dreadful feelings that produce a sense of guilt they have tried to control or deny. Some parents think that perhaps the angry feelings within themselves have a magical power and may have impaired the fetus at conception or during gestation. Some wonder whether their child's retardation is not a punishment from God because of their past sins, or whether God has not blessed them by giving them a retarded child as a symbol of innocence, purity, and holiness.

Parents always express these thoughts about God, tentatively, with awe toward mysterious, seemingly irrational forces and at the same time with bitterness, irony, and doubt. The question persists: "What did I do to have had this happen to me?"

Feelings toward the children

Feelings toward the retarded children gradually emerge. Some parents see the children as grotesque objects to be hidden from public view and from friends and relatives. As such feelings come to light, they become attached to the parents' self-image. The parents feel inwardly grotesque and are afraid of being regarded as genetically imperfect, contaminated, and inextricably identified with the damaged child.

Mrs. Z. said angrily that before her retarded child was born, her mother-in-law boasted that among her 14 grandchildren there was "not one crooked finger."

Mrs. Z. said with a laugh that she thought there was a little of the mongoloid in all of her other children too, as several of them had the simian line and blunted fingers. After the birth of the retarded child, her mother-in-law would not go near him. She suggested that the Z.'s place the child in an institution and was disappointed when they took him home. Once when the father was going to visit a relative, she urged him to take one of the normal children along so that "they could see you are capable of having normal children."

As the parents describe the cruelty of others toward them in their misfortune, many reveal their own harsh and punitive views of themselves. These are gradually modified by the gentle, kind, perceptive judgments offered by other members of the group.

Mr. S., in an angry voice, told about taking her retarded daughter to a party and, after leaving her side for only a few minutes, being accused by the child of trying to abandon her. Mrs. J. described her embarrassment when she took her retarded son to get a haircut and he tried in his jumbled speech to talk with the barber. Mrs. V. told how *her* son had run excitedly into the living room speaking incoherently when the family was entertaining company. When she tried to calm him down, he had become so excited that she had to send him to the basement. Mr. and Mrs. F. admitted rather shamefacedly that they never took their daughter anywhere because she was so obviously retarded. Mrs. S. confessed that when she took her daughter anywhere she had a strong impulse to shout, "She's a retarded child!" and had real difficulty in controlling it. The group, shocked, fell silent.

The worker pointed out that all the parents apparently had these feelings of embarrassment and discomfort and asked what understanding, what thoughts they had about them.

Mrs. F. said "shame and humiliation." She said she felt like hurling something at them, those who looked at the child, those who thought she was different; she wanted to attack them and defend her child. Mr. V. said "resentment and anger" for having such a child. Mrs. E. said, "I want to say to them, well, what are you looking at?" Mrs. T. said, excitedly, "I used to do that, think that. I used to stare at them, but now I avert my eyes." Mr. F. said, "I am guilty of that, too. Inside you feel inferior, ashamed."

Mr. T. said they had left their daughter Betty at a party that night with great apprehension, for they had never left her at a party before. "My mind is there while I am talking," he said. "Betty talks, talks, talks. The people we usually leave her with when we come here are out of town. It is important to come here; we have never talked about our feelings about her with anyone else before, never even with relatives or friends." Mr. F. said, "We come here for the child as well as ourselves."

Mr. E. said he wondered whether all these feelings we were talking about were not due to the hurt inside the parents. The child, he thought, does not suffer so much as the parents. Mr. T. agreed, "It is because you feel there is something wrong with you that you should have a retarded child."

Mrs. F. spoke of knowing a 19-year-old retarded boy whose parents take him everywhere. "Maybe it is our fault when our child embarrasses us. Maybe he picks up our feelings about him."

Eventually, the group enters a period of alternating grief and solace: themes of loss and death alternate with themes of how gentle and lovable retarded children are and the solace they offer the family. The parents' fears that the children might die are based on reality, for many retarded children have other congenital defects that add to the difficulty of caring for them and fill their parents' days and nights with apprehension.

The parents praise each other's children, and during the expression of such positive feelings they slowly venture to speak of their anger and fright at the persistent intrusion of intense death wishes. Many say in effect, "Having a retarded child is like having a death in the family, only worse; at least you can get over a death, but this is never behind you. You

have to live with this—for the rest of your life."

When the group members become aware of the intense feelings this theme arouses, they move away from it. Many indicate they do not want to look ahead very far. Groups are often quite free from expecting false assurances and are quick to challenge platitudes. The retarded child is an inescapable reality. The future is feared because the child must surely present more difficulties as he grows; his faults and defects will be magnified. Some parents express the wish that the child will remain an infantile love object to be cuddled and pampered, of whom little need be demanded. Conversely, some parents note that in remaining like an infant the child will be an ever-increasing burden, tyrannical in his need for attention and care.

Each parent in a couple seems to fear that the other will be drawn to the retarded child so strongly that all others in the family will be neglected. This leads to anger and a sense of guilt in an alternating repetitive cycle.

Parents often screen their doubts and misgivings about the extent to which they might express their innermost thoughts in the group with expressions of concern about what to tell their other children, relatives, friends, and other persons in the community. However, parents frequently say they feel both relieved and surprised after they *have* expressed a strong negative feeling or fear. They wonder that they have been able to say things in a group that they had never been able to say to a husband or wife or a best friend. Their feeling of relief, however, is soon followed by further doubts and fears of revealing deeper feelings.

So great is the need among such parents to protect their self-esteem that a group sometimes subtly divides into sections: one, parents of children who are only mildly or moderately retarded and have only slight or no physical defects; the other, parents of children who are severely retarded or whose retardation is also apparent in their physical appearance, as with mongoloid children.

Signs of strength

Each member of the group feels defeat, but many have also had experiences that have given them a sense of victory—moments of small triumph whose import they feel the "outside world" is not equipped to understand. For example, a parent may say, "Our retarded children are different; we can shed tears together. But we are alert to and take pride in every sign of small improvement in them. Every slight step forward, which would be unnoticed in our normal children, is a major triumph in the handicapped child."

Arthur Mandelbaum is the chief social worker at the Menninger Foundation, Topeka, Kans. He is also secretary of the American Association of Residential Centers for Children and second vice president of the National Association of Social Workers. He received his master's degree in social work from the University of Denver in Colorado. He has written many articles for professional publications.

The group members usually identify with one another in an intense and binding fashion. They seem to feel that since their children are unusual, they themselves are unusual also and belong together. Sometimes they are united against the "outside world"; sometimes against the leader of the group, a representative of that outside world.

Mrs. T. said that for 2 years she would not admit to herself that her child was retarded. She recalled the first doctor she had consulted about the child, and she said she hated him. Mrs. N. suggested that perhaps Mrs. T. hated the doctor because he was the first person to tell her about her child's retardation. Mrs. T. agreed. The discussion then became heated as the group members spoke of doctors, how they were told about their child's handicap, and their need for someone to talk with.

For the first time, two or three parents spoke at once. The worker, raising his voice slightly to be heard, pointed out that the parents were saying three important things: first, that the doctor, by giving them the diagnosis, had hurt them; second, that the doctor had failed to help them in the way they had wanted at the time of their first deep shock; third, that they had found consolation in talking with others with the same kind of problems through the parents' association and that outsiders did not understand and could not help very much.

The parents agreed to this. Then the worker pointed out that several times previously he had tried to get into the discussion but that they had been so intent on getting their points across that he had not been able to do so. He asked whether they were aware of this and, if so, whether they could understand why.

Mr. P. quickly said, "You are an outsider, too." The worker said he thought this was an important point. Mrs. T. pointed out that one of the "professionals" on the staff of the parents' association was supposed to attend a meeting of the school board but had been "too busy" to do so. If he were a parent of a retarded child, he would have been there, she added, but professionals did not have the same kind of concern as parents. Mrs. N. said that the man's absence probably had nothing to do with his being a professional person; even some parents had to be pushed to attend meetings.

When the group session ended, the parents remained stand-

ing outside the building as the worker drove away. Mrs. S. waved goodbye, saying, "You see, we are going to continue outside in the cold."

As the discussion explores the labyrinth of feelings, the parents grope toward mature ways of viewing behavior in an attempt to find a value system that is right for them, one that will sustain and nourish them. They support one another, bring out feelings for the scrutiny of the group, question irrational ideas, point up the inefficiency and dubious value of certain kinds of behavior, and gradually increase the ability of each person in the group to look realistically at the problems presented by his retarded child and ways of dealing with them. The worker must have faith in the inherent ability of the individual parent to release his capacity to do this—a capacity previously blocked by anger, conflict, and fantasies. If he does not have such faith, he will intervene hastily in the group's discussion and become authoritative and didactic, and in doing so dilute the emotional intensity of the experience for the parents.

The leader's role

Using the group process to help parents is an increasing clinical practice in service to the mentally retarded. The worker who attempts the process must be skilled in dealing with persons in one-to-one interviews, *preferably before* he attempts to deal with them in groups. If he chooses the group method because he is discontent with the one-to-one method, he should know that in trying to help individual parents through the group process he takes on a task of greater complexity, one requiring an understanding of the dynamics not only of individual behavior, both normal and abnormal, but also of the behavior of groups. If he is discontent with the slow, cautious movement in the one-to-one process and expects a more rapid progress in working with a group, he will be disillusioned. In either method the worker must be aware of the recurrent nature of grief in parents of retarded children and of the adhesive quality of their inner conflicts. He must know that he will win the group's confidence and trust only after repeated trial and error and that each member of the group grows at his own pace.

It is tempting to use the group meeting to teach parents facts about mental retardation, to answer their questions about their children, and to discuss at length the reasons for their children's slow development. Listening and observation, however, will quickly show the worker that many parents in the group are very well read on the subject of retardation and that some have become learned on specific aspects of the problem and are much closer to being masters of the subject than the worker. Instead of teaching, the worker helps the parents deal with their inner problems by using his knowledge that sorrows can be borne if they can be put into words or into a story; can be absorbed or dissolved if they can be expressed in words to those who face the same inescapable adversity and who wish to examine that adversity as it affects their inner selves. His task is to help the parents see the import of what they are saying and feeling as the discussion weaves back and forth between the way individual members feel about being parents of a mentally retarded child and how and what they understand about their world, themselves, and each other.

To the group the worker is an outsider. As the parents speak about professional people not understanding, about their treating parents abruptly and harshly and not helping in the way the parents want and expect, the worker must use the strictest self-discipline to control his anger, for it becomes clear that the parents also consider him an outsider incapable of helping them and unable to understand their feelings because he has not had the same shattering experience as they.

The worker is like a screen against which are projected the parents' feelings toward all outsiders as critical, uncaring, judgmental, and punitive. He represents all authoritative figures who have failed to protect the parents from an irrational and malignant fate, who will not give answers, and who force them to think for themselves.

"Will no one give us answers to our grief, will no one hear us?" The cry at first silent is soon voiced more and more. The language of the group is commonplace. It is concerned with the ordinary aspects of experience, but suddenly, and sometimes without warning, it slips into expressiveness or expressions that give the speakers themselves a shocking glimpse into their deeper feelings—

"Do you ever get over it, the depression, I mean?"

"I felt that being around friends who were pregnant was like some curse."

"What did I ever do to have had this happen to me?"

"Sometimes, I wish he had died at birth; the doctor should have killed him and not told me."

"When I did bring the baby into the store, the clerks all admired her and cooed. I wondered whether they knew she was retarded and they did that just to please me. Then, when I

didn't bring the baby, they asked about her. I felt guilty and wondered whether I had left her home because I was angry. Maybe the fact is, I'm too sensitive."

The conversation is sometimes drab, superficial; the speakers grope to convey information, search restlessly for contact, for understanding, for an illuminating explanation of the myths, theories, and conflicting beliefs about retarded children. In this search they express fear that the worker will see them as damaged, inferior, and ill and will not see their strength. Then, of course, they hesitate as though wondering how much it is safe for them to see and understand.

They become angry and seem to feel that the group process means they are to devote their lives and their dreams exclusively to the retarded child, to the neglect of their other children and themselves.

They seem to wonder: Are they in bondage? Will the worker let them go? If they express the full measure of their thoughts, their anger, will they be able to control those feelings after they leave the group and do not have each other for support?

They seem to wonder, too, about the worker and his relationship to them: Will he, because of the intensity of their concern and anger, become overburdened and ill? Is he preoccupied with his work, too professional, insensitive, and unobservant to know how they really feel? When a meeting is canceled because he has to be away, where does he go and to whom does he give the words of wisdom that he is denying them? How can they make him do their bidding and gain mastery over him so that he can gratify them more?

These and other questions the parents sometimes ask directly, sometimes imply in their questions or statements about their retarded children, their families, and their lives outside the group. But little by little they delve beneath the clichés and superficial questioning to deeper layers of meaning until they can see the hitherto undreamed of nature of their own true feelings.

Time and time again, parents express surprise about their former narrow views of their families, other people, and the institutions of society and what needs to be done about them. They also express hope about finding ways to handle the tasks ahead of them.

The end of these sessions is like the termination of a voyage. The passengers have come together; have talked, laughed, cried, struggled to share feelings and to achieve deeper, wider understanding of themselves and their children. They have formed close friendships. Now it is time to say goodby.

The members of the group express regret that the group cannot continue in its present form. They express fear of letting go of something that has been helpful and of being alone again. Each member, however, as a member of the larger association of parents of retarded children has an opportunity to help formulate and work in behalf of retarded children. Having, through the group process, focused his attention on himself and on others in a series of interactions in which he both gained insight and lost some of his exclusive preoccupation and self-interest, he is the more ready for social action. For as Aldous Huxley has noted, "The more inward we are, the more we may undertake outward activities; the less inward, the more we should refrain from doing good." [3]

---

[1] Cohen, Bernard: In the foreword of "An introduction to the study of experimental method" (Claude Bernard). Dover Publications, New York. 1957.

[2] Solnit, A. J.; Stark, M. H.: Mourning and the birth of a defective child. *In* The psychoanalytic study of the child, vol. 16. (Ruth S. Eissler et al., eds.). International Universities Press, New York. 1961.

[3] Huxley, A.: The devils of Loudon. Harper & Bros., New York. 1953.

Youth will not be well served if we assume tomorrow's world as an unchangeable "given"—a mere . . . extension of the world we presently know. . . . I find no joy in being adjusted to measureless violence, hand-to-mouth and catch-as-catch-can existence, or to a deepening phoniness which embitters the mind, blights the spirit, and saddens the dreaming heart of man.

Rev. Dr. Joseph Sitler, Professor of Theology, University of Chicago, to the 1960 White House Conference on Children and Youth.

SOME OBSERVATIONS ABOUT MENTALLY RETARDED ADOLESCENTS

ARTHUR SEGAL

The term "adolescent" usually produces an image of a young person struggling to leave childhood for adulthood. We think of his "search for identity" [1] and his use of relationships with his peers to support his ego during this period of confusion.[2] We have come to regard adolescence as a distinct developmental period with its own norms and cultural values; a stage when the young person compares and challenges the forms and meaning of his own and others' behavior.[3]

Parents and other adults significant in an adolescent's life often try to help him through this tense period by providing him with opportunities to explore ideas and initiate plans for the future. But what of the mentally retarded adolescent? Does he feel the same kind of tension from the conflicting pulls toward both childhood and adulthood as the normal adolescent? Does he too begin to question the familiar and to wonder about the future?

Observations of young people in the work-training and recreation programs operated by the San Francisco Aid Retarded Children, Inc. (SFARC), have convinced me that they do. There are, however, subtle differences between the forms and degrees of their questioning and tension due not only to the degree of their retardation but also to the amount of self-confidence they have been able to develop through the support and understanding of adults. In many of them the normal tension of adolescence has been aggravated by the realization that somehow they are "different" and that this will make a difference in the opportunities they will find.

The mildly retarded adolescent (IQ between 53 and 68) speaks the language of the adolescent culture. He wants a job and wants to earn a salary. He is aware that he has been classified as a mentally retarded child and he resents this. He resents being expected to limit his career to work in a sheltered workshop and longs for the kind of job held by his father or friends. He speaks of sex and marriage and wants to date. The kind of heterosexual relationships he has is probably affected more by the standards of his friends than by his level of intelligence.

Mildly retarded young people are sufficiently aware of their deviance to be angry. However, their limited ability to understand abstract social relationships and to plan and control their participation in community activities often leads to diffuse expressions of emotion. They do not know where to direct their anger—at themselves or at the adults who do not believe in them. One girl described her confusion about where she stood as a person by saying, "Sometimes I feel like a child is holding on to me and won't let go."

The moderately retarded adolescent (IQ between 36 and 53) also shows awareness of the values and customs of his community and indicates a desire to participate in them. However, the participation he expects may be on another level. He is usually less socially adept and independent than the mildly retarded adolescent. His manner of expression is often closer to the preadolescent than the adolescent form and his display of interest in adult customs usually reflects this. He regards work as fun but play as more fun. He approaches boy-girl relationships shyly, usually with a lot of giggling and perhaps

some hand holding. He tries to imitate the adult he sees on television, the adult he believes he should be, and his inability to do so is evident to him.

The moderately retarded adolescent is also aware that the activities and accomplishments expected of him in "school"—for him a special class for "the trainable mentally retarded"—differ from those expected of his brothers and sisters in regular classes, and he speaks of wanting to learn to read and to acquire other academic skills. He is aware that children become adults when they complete secondary school. He has a general idea of the tasks and relationships expected of adults, and as a result he feels somewhat in limbo—no longer a child, yet barred from adulthood. Then what? One 18-year-old boy, upon graduation from the school's program for trainable mentally retarded children and adolescents, summed up his state as now "half a man and half a kid."

The severely retarded adolescent (IQ between 20 and 36) also has some awareness of his "difference," but he usually has some difficulty expressing himself. He has fewer words at his command and his understanding of others appears to an observer to be limited to their connection with his familiar routine. However, what seem superficial to the observer of a severely mentally retarded adolescent may reflect the observer's inability to communicate with him.

At SFARC we learned through various techniques such as the casework interview, role play, and puppetry that an older teenager who is severely retarded may still have specific interests related to his chronological age rather than to his level of intellectual development. For example, one girl let us know in very few words that she liked to play checkers with her 6-year-old cousin but that she did not play with dolls because "they are for kids."

However, the ability of a severely or moderately retarded adolescent to recognize that he is different does not mean that he necessarily understands the nature of this difference. When a group of such young people are together their discussion often reveals their identity confusion, their desire to be adults, and their limited understanding of adult ways. This is illustrated by an excerpt from a record of a meeting of the Hawks, a recreation club of moderately retarded adolescent boys.

When the group voted to visit the zoo, Jerry suggested that they also visit the adjacent playground. The boys thought this would be fun. Then Tom asked about activities at the playground. Jerry, who had visited the playground several times, answered, "swings," and smiled with a look of anticipation. There was a momentary silence. Then Ron, Tom, and several other boys pointed out, sneeringly, that swings "are for kids" and they were adults. Jerry looked confused, and Bill said he thought adults could go on swings. However, the majority of the boys voiced strong negative feelings about acting like kids, and the decision veered in the direction of adult behavior.

But what is adult behavior? While these young people obviously saw it as "not childish behavior," they could not easily say what it was nor follow through in a determined way.

The confusion among severely and moderately retarded adolescents about what an adult's role consists of may be due not only to their low level of intelligence but also to their lack of opportunity to learn the things that other adolescents learn incidentally in their daily lives. For example, in one of the discussion groups of moderately retarded adolescents conducted at SFARC to promote a greater degree of self-confidence in the retarded, some of the young people talked about how much they would like to live alone, but they showed almost complete ignorance about what a person who lives alone has to know and do. They knew almost nothing about the prices of food and rent or the tasks involved in getting in supplies, preparing meals, and cleaning house. But after they were taken by the social worker on trips to grocery and department stores and listened to a landlord talk about rents and the kind of care a tenant has to take of the rented unit, they begin to show a more realistic understanding of what it means to be an independent adult.

Effects of labeling

Identity confusion may stem from a multitude of inconsistent and distorting experiences in the mentally retarded person's life. From the time he has been labeled as mentally retarded he has been regarded as a social deviant. As a result he has been put into a mold which inevitably has shaped his personality. For example:

Mr. and Mrs. L. have "a cheerful little girl," Penny, whom they dearly love. Penny has Down's syndrome, and from the time the diagnosis was made the parents have been subtly influenced to use the mold. Their daughter will remain a child, she will never grow up, they have been told by physician, teacher, neighbor, and relative.

The L.'s have a good marriage, and have other children of normal intelligence. They have decided that, since Penny cannot grow up and cannot understand adult concepts, they will always respond to her as though she were a small child. They have always laughed at her antics and given her the secure care a child needs, and they have continued to do this after she is well into adolescence.

Thus, Penny has learned to expect easy forebearance and

close supervision from her parents. Since she has never had any friends of her own age, she has had neither socialization experiences nor parental encouragement to guide her into adulthood. Therefore, she does not learn new socialization methods appropriate for an adolescent.

Penny *could* learn social behavior more appropriate to her age, for many young people with her condition have done so. But as long as her parents and other people in the community and she herself believe she is a child, she will remain a child.

The same molding process takes place in some families with a mildly retarded child, though much less frequently. Our experience at SFARC with adolescents who are only mildly retarded or who are on the borderline between retardation and low normal intelligence suggests a different set of dynamics.

Many parents who have an adolescent child who can almost make it academically do not wish to dwell on or even admit to the fact of mental retardation. They tend to push the child toward greater academic achievement or job finding. They do not wish to be counseled on ways of dealing with a retarded adolescent. Some parents only allow themselves to refer to their child as retarded because the agency accepts only the mentally retarded in its job training programs. Some only agree to accept counseling for themselves if this will guarantee their child a job. Some insist that their child is just lazy.

A mildly retarded adolescent, therefore, is apt to be caught in a vise of conflicting images and expectations. The school labels him as mentally retarded and puts him in a special class. His parents say he is lazy. He himself may be sure he is neither lazy nor mentally retarded. But he has to live with both labels, a task made more difficult by his limited intellectual ability and its effects on his social judgment. When he shows the typical tension and questioning attitude of adolescence, he receives little pertinent guidance from adults because they either see everything he does in terms of his retardation or fail to recognize the difficulties his retardation causes him.

Many mildly retarded adolescents, while vaguely aware that they have trouble learning, do not look on themselves as abnormal. Therefore, when they enter a training program in an agency whose name itself shows that it serves only the retarded, they have added to the usual difficulties of adolescence the psychological problems that come with labeling. Many of them rebel and leave the agency.

At SFARC we have seen many mildly retarded adolescent boys and girls who, having dropped out of school or completed a program of special classes, have agreed to attend the sheltered workshop for training but have not agreed to be mentally retarded. They stay on in the workshop as long as they think it will lead to an outside job.

A survey of mentally retarded persons known to 31 agencies in San Francisco shows a discrepancy of several thousands between the number of persons of school age identified as mentally retarded and the number over 18 years of age. The following case story may offer a clue to this discrepancy:

Dan B., a mildly retarded 18-year-old school dropout, registered at the SFARC workshop. His parents placed a high value on work and independence. Mr. B. insisted Dan was lazy. Mrs. B. hoped Dan could get a job. She was not certain he was retarded.

At the workshop, Dan was sullen and apathetic. He did not like the program nor the trainees, most of whom were more retarded than he. He became embroiled in many fights. The staff tried to give him special work activities, but he would not stay.

The agency lost track of Dan for about 2 years. Then one day he appeared at the workshop beaming. He had a job with a service station and was earning a union wage. He was married, and his wife was pregnant. He returned again the day after his wife gave birth, a happy father, obviously no longer identified as mentally retarded.

When will I get a job?

Every adolescent we meet in the SFARC training program asks the same question: When will I get a job? Behind this question are many influences: cultural standards, tradition, the inner need for identification, and the need to be a productive person. Some trainees expect jobs in specific occupations in the community; others are content to remain in the sheltered workshop. Some expect a higher wage than the workshop offers; others want a wage only as a symbol of adulthood and are not concerned with its size.

The *severely retarded adolescent* usually wants to remain in the workshop where he has a meaningful task he can accomplish.

The *moderately retarded adolescent* is more likely to speak of a "real job," though he has little notion of the requirements for such a job. He may want to become an electrician, a policeman, a teacher, or, after some interviews with the agency's caseworker, a social worker. He wants to be regarded as adult, a state he equates with having the same kind of job as a particular adult he knows and admires. Most moderately retarded trainees, as they form positive relationships with the agency's staff members and gain new skill and a degree of independence, are able to relinquish their original vocational goals and take

jobs in the workshop or the community that are within their competence.

The *mildly retarded adolescent* usually has less uncertainty about his ability to become an adult and more realistic vocational aims. He wants a job in the community that pays good wages instead of workshop employment, though he may be completely lacking in any vocational skill and in the social skill it takes to get along with fellow workers and a boss. Mildly retarded adolescents are well aware of the puritan principle that commands the "worthy" to work, and so they feel greater pressure often exerted by their parents to seek work in the community.

Love and marriage

Like most young people, mentally retarded adolescents are interested in the opposite sex. In the SFARC workshop we often heard conversations among the young people about "boyfriends" and "girlfriends," about dating, marriage, and sex. However, love and marriage, though talked about by almost all the young people, have different meanings for different persons.

Among the *moderately retarded* talk about love or marriage is usually only an expression of a cultural expectation. For example, for John, who is moderately retarded, getting married is something adults do. Since he is approaching adulthood, he too will have to marry, or so he fears. When he speaks of marriage he is really expressing his search for an adult image.

Mary, also moderately retarded, is a very lonely girl who has lived in a number of foster homes. She met a boy at the sheltered workshop and soon began to speak of love and marriage. Her desire, we observed, was for a comforting relationship with a male figure. Mary and her boyfriend will both remain satisfied if they can continue their friendship.

Young people who are *mildly retarded* or near the borderline of dull normal intelligence have a more sophisticated view of marriage. They speak of finding a job, an apartment, and of all the things young people normally consider before marriage. And many of them do get married.

Many persons—especially parents of the mentally retarded and professional persons who work with them—raise strong objections to the idea of mentally retarded persons getting married. The objections raised most frequently are: (1) mentally retarded persons cannot make realistic plans; (2) they may produce mentally retarded children; and (3) they may be unable to care for children properly. The tendency is to approach the subject negatively without recognizing the varying degrees of retardation and personality development among persons who score low on IQ tests or the lack of evidence that successful marriage bears any relationship to specific levels of intelligence. Moreover, nobody has ever developed a standard model of a successful marriage against which the marital adjustment of a retarded person could be measured.

There are two reports in the social work literature of studies involving inquiries into the marital adjustment of persons who were mildly retarded. Both show an association between marital adjustment and the personalities of the marriage partners—a result that one would certainly expect to find in a study of marital relationships among nonretarded persons.[4, 5]

Concern about the progeny of a marital union between mildly retarded adults may be overemphasized. The etiology of mental retardation is complex. Only a small proportion of cases can be linked to known genetic factors. But the presence or absence of certain environmental factors in childhood and adolescence decisively influences opportunities for intellectual achievement and social growth whether or not retarding genetic factors are present.[6]

The ability of parents to provide and care for their children properly is determined by several factors other than intellectual ability. These include emotional stability, economic security, and community acceptance. Since marriage does occur between mentally retarded persons and some of these unions do produce children, whether or not skillful guidance is available to them is an appropriate concern.

The parents

Parents of mentally retarded adolescents often need guidance to help them help their retarded child achieve a greater level of maturity. They may be unable to let the child grow up, not because they do not want him to, but because they are afraid that he cannot and will be hurt if he assumes more independence in getting around the community, going shopping alone, or taking a job. Parents have many deep and lasting feelings of grief and sorrow about their retarded child that must be understood and respected by anyone who wishes to help the mentally retarded adolescent.[7] Such feelings cannot be dispelled, but parents can be helped to explore their mentally re-

Formerly chief of social service, Independent Living Rehabilitation Program, San Francisco Aid Retarded Children, Inc., Arthur Segal is field work supervisor for the School of Social Welfare, University of California, Berkeley, and a board member of the San Francisco Coordinating Council for the Mentally Retarded. A graduate of the Columbia University School of Social Work, he has also worked in rehabilitation agencies in New York.

tarded child's abilities and to permit him to grow up.

Parents who have had no guidance during the child's formative years are usually not prepared for understanding and helping their child when he becomes an adolescent. We have known parents who childishly teased and chided their retarded adolescent child on the assumption that he did not understand them enough to care. At SFARC we were able to show such parents that the young person does understand them and no longer wants to be treated as a child. I use the word "show" literally. Some parents have had to be shown their teenage child actually working at a productive task or participating in a group discussion before they could believe in his potential for functioning more maturely.

In contrast, some parents of mildly retarded adolescents express disbelief in their child's retardation. This is often true if the child's retardation was not recognized by anyone until he reached school or even later when the school belatedly placed him in a special class. Such placements are frequently made with little or no interpretation or guidance being offered the parents. If they have a poor understanding of English or little concern for academic achievement, they may not worry about their child until he grows older and exhibits an inability to compete socially and in job getting. Parental misunderstanding of the young person's behavior may then lead to friction and tension.

At SFARC we encouraged parents to come together in discussion groups as one means of helping them get a clearer picture of their retarded children's potentials as young people growing into adulthood. In discussing together the meaning of independence to specific retarded adolescents (their own child and each other's), the ability of these young people to assume responsibility for decisions, the pros and cons of allowing them to date members of the opposite sex and, eventually, to get married, and their chances of employment, the parents often come to see that the potentialities of each retarded adolescent are different and to drop the tendency to say that "the retarded can" or "the retarded cannot" do something.

For example, a mother of a girl employed in the sheltered workshop repeatedly expressed the fear that something would happen to her daughter because she was taking long walks with another girl after work instead of coming directly home every day. This mother gradually relaxed when other members of the group kept telling her that her daughter was behaving like other teenage girls and was in no greater danger than they in taking a walk with a friend.

We found that parents who refuse to permit their retarded adolescent son or daughter to develop greater independence tend to be those who are uncomfortable in their relationships not only with their retarded child but also with their normal children. When we have been able to help these parents, through the group and through individual casework interviews, to relax their attitudes toward their retarded child, we have found that their attitudes toward their other children have also changed. When they finally could permit their retarded adolescent child to assume some independence, they could also encourage greater independence in their other children.

IF RETARDED ADOLESCENTS are to be helped to achieve more satisfactory lives, all those who are working in their behalf—parents and professional persons alike—must recognize that these young people are *adolescents*, with all the desires, expectations, and confused emotions that come with adolescence, and at the same time are *individuals*, each with his own personality, own special way of looking at things, and own degrees of strength, weakness, and potentiality.

---

[1] Erikson, E. H.: Childhood and society. W. W. Norton & Co., New York. 1950.

[2] Sherif, M.; Cantril, H.: The psychology of ego-involvements, social attitudes, and identifications. John Wiley & Sons, New York. 1947.

[3] Maier, H. W.: Adolescenthood. *Social Casework*, January 1965.

[4] Peck, J. R.; Stephens, W. B.: Marriage of young adult male retardates. *American Journal of Mental Deficiency*, May 1965.

[5] Wolfson, I. N.: Follow-up studies of 92 male and 131 female patients who were discharged from the Newark State School in 1946. *American Journal of Mental Deficiency*, July 1956.

[6] Gruenberg, E. M.: Epidemiology; Anderson, V. E.: Genetics in mental retardation. *In* Mental retardation. (H. A. Stevens and R. Heber, eds.) University of Chicago Press, Chicago, Ill. 1964.

[7] Olshansky, S.: Chronic sorrow: a response to having a mentally defective child. *Social Casework*, April 1962.

EXTENDING A HAND to PARENTS of DISTURBED CHILDREN

JOYCE EDWARD

Now that the right of the emotionally disturbed child to education is firmly established, those of us who work in special education can direct our efforts toward the challenge of insuring that every emotionally disturbed child likely to profit from special education receives it. To meet this challenge is not so easy as it may appear. Parents can be the greatest obstacle. Some parents resist accepting a reliable diagnosis of their children's disorder as disturbed and are unable to follow recommendations for special class placement.

Ten years of experience as a psychiatric social worker in the elementary school division of the Luther E. Woodward School for Emotionally Disturbed Children, Inc. (LEW), in Freeport, N.Y., which takes children aged 4 through 16 years, has made me much aware of the problems of the parents of disturbed children and of the measures an agency can take to help these parents accept their children's special needs. At LEW, casework with families is an integral part of the program from intake to discharge. We have found that, though placement of the child in a special class is usually painful for parents, it is a process through which they can be helped to reach a better understanding not only of their child and his needs but also of themselves. What the professional worker does can have a great deal to do with whether the parents' adjustment to the child's placement improves as the child improves or whether it disintegrates, leaving the parents even less effective than before in helping their child.

Basic to the professional worker's efforts is the recognition of both the conscious and unconscious effects the disturbed child has on his family. The problems parents expose to professional workers reflect their individual personalities, the interactions of the entire family, and the actual difficulties they face in rearing a disturbed child.

The severity of the symptoms of such a child can of themselves make even healthy, stable families anxious and defensive. The child's hyperactivity, impulsiveness, bizarreness, regression, and obsessiveness, to mention only a few characteristics that may occur singly or in combination, place an inordinately heavy strain on family life. The behavior that makes a child unmanageable in a regular school class makes him no less so at home. His care is taxing; his behavior is incomprehensible; his conduct can be embarrassing; the medical attention he requires is costly; the social services he requires are difficult to secure; and the time his care requires is excessive. His illness is a severe blow to the parents' self-esteem, and their feeling of guilt for having produced such a child is accentuated by the hostility and anger the child provokes. It is difficult for them to air their feelings or to separate themselves from him. Even the most mature parents worry about how to handle an emotionally disturbed child without harming him further. They worry not only about the present but also about the future.

In addition to having problems directly related to the child's disorder, parents may be beset by other kinds as well. Some have serious psychiatric disorders themselves. Complicated pathological relationships may exist in the family, of which the child's

illness may have become an integral part. Some parents cannot view their child's disorder realistically because they identify themselves with his behavior. Others are so limited intellectually that they cannot understand what professional people tell them about their children. Social and cultural deprivation hinder others from understanding. Or daily problems stemming from economic want, bad health, or poor marital relations may contribute to the parents' inability to act wisely for their child.

Of course, the school is not responsible for helping parents solve all their problems, but unless the school recognizes that many influences affect the ability of the parents to come to grips with their child's disorder, attempts to secure their cooperation will not succeed. There is an important difference, for example, between a parent who fails to keep an appointment because he has no transportation or can get no one to care for other children and a parent who fails because he fears the school or is hostile toward his child. There is also an important difference between a father who in momentary anxiety and defensiveness denies that the acting-out behavior of his son represents a serious problem and a father who denies the existence of the problem because he himself is psychotic and sees his son's actions as justifiable retaliation for an imagined insult to the family. What we as professional people do to enlist the parents' support is determined by the degree to which we recognize that their actions are as symptomatic of their needs as are the child's of his.

Sometimes parents are unable to comprehend the explanation we offer them about their child's illness or, if they do, they cannot act positively on the information for various reasons. The emotionally depressed father who is told that his son needs more attention may never have been able to form a meaningful relationship with another person and certainly does not know how to form one with his disturbed child. The disorganized, perhaps mentally retarded, mother who is told that her child could benefit from sound eating and sleeping habits may be completely unable to put this suggestion into practice without a great deal of support.

It is not enough for the helping person to be aware of the parents' feelings, however. As professional persons, we must be cognizant of the kinds of feelings parents arouse in us. Our reactions to parents contribute as much to the climate of interchange as the parents' reactions to us. We all have feelings about parents as such, for we have all been children. We may transfer either positive or negative feelings, depending on our own experience. To work successfully with parents, we have to control our own unsound reactions. We may, for example, react to the parents of disturbed children with hostility because we think they are responsible for their children's troubles. We may have a feeling that if we could only rid the child of his noxious parents and have him to ourselves we could effect a "cure."

Unfortunately, such feelings are often communicated to parents, and their recognition of these feelings may account for some of their resistance and hostility. When we realize that mental illness in childhood is the result of a complex interplay of biological and environmental forces, we will no longer assume that all parents of disturbed children are alike. Whatever contribution the parents make to the child's problem are most likely unconscious reflections of their own psychic difficulties. Our anger at the parent only increases his anxiety and impedes even more his ability to improve the quality of the care he gives his child. To control our own reactions to these parents is no easy task, for their behavior is often provocative and productive of irritation.

Parental anxiety

It has been my experience that where the parents' anxiety is primarily a reaction to the child's disorder and not symptomatic of pathology, an understanding attitude on the part of the professional person promotes the development of a positive relation between family and school. In time, this relation becomes the cornerstone for the work between the family and the school and enables the parents to trust the school's judgment and to accept the educational plan the school recommends as a logical outcome of a joint endeavor. This is never an easy process, however. When the child enters school, parents must face the child's problems squarely. The school must be prepared to work with families in a crisis and to give even healthy parents the support they need to resolve their problems and enough time in which to do it. Accepting the fact that one's child does not fit into the public school, one of the most basic institutions in society, cannot be worked through in one session. We must be prepared to help parents through a painful time when their thinking may be muddled by pain. We must remind ourselves that some conditions in life are never really accepted but are only tolerated by those who must face them, and that for most families of chronically handicapped children sorrow persists throughout life.

For mature families the process of working with persons from the school to secure the right educational plan is in itself helpful, for it tends to lessen anxiety. The knowledge we share with the family about the nature of the child's disorder, the educational plan recommended, and the child's development help them learn to control their anxiety through intellectualization. It also gives them enough time and experience to correct distortions about the child through consistent opportunities to test reality. Regular, planned meetings with parents are basic to a good special education program, and they can be as important to mature parents as to immature.

Parents who, despite the sensitive professional effort extended to them by the school, continue to deny the problem and project their difficulties onto the school cause great concern in professional workers. If the diagnosis of the child's condition is accurate, the parents' reactions to it often indicate the degree of disturbance in the family. The parents may themselves require special help. However, whatever blocks their ability to accept assistance for their child is also likely to block their willingness to seek help for themselves. Nevertheless, schools must work with these parents to the best of their ability if the right educational plan is to be made for the child.

Two cases of work with parents of children sent to LEW back up my points. In these cases, each couple's problems were reflected in the difficulty they had in accurately sizing up and solving their sons' problems. Both members of the first couple, Mr. and Mrs. G., have emotional problems of long standing that have resulted in marital discord. They are intelligent and are sophisticated about psychological problems. The other couple, Mr. and Mrs. L., are both paranoid and extremely withdrawn, hostile, and suspicious. They are not intelligent and are economically and culturally deprived. Despite difficulties, however, their family is intact and self-supporting. Both families are concerned about their children and their education.

Fred's parents

Mr. and Mrs. G. at first greatly resisted the idea of placing their 10-year-old schizophrenic son Fred in a special program for mentally disturbed children and had difficulty tolerating the placement for a long time. Psychiatric and school reports indicated that the school had tried to help Fred and had kept him in regular class as long as possible. When the parents came to LEW, they were agitated and quarrelsome, accused each other of being at fault, and showed the resentment they felt against the school for recommending special placement. Mrs. G. soon took over the interview. Although Mr. G. seemed more realistic than his wife, he only contributed to the interview when questioned directly. But as Mrs. G. always contradicted whatever he said, he gradually grew silent.

Mrs. G., while admitting there was something wrong with Fred, said he was not so ill as the children in our classes. As the interview progressed, it became apparent that Mrs. G. hoped the caseworker would, on the basis of the referral material, confirm her belief that the school had failed the boy and that all he needed was a regular class of higher quality.

The caseworker acknowledged that it was difficult to accept a special class like ours but said she felt that, despite their doubts, Mr. and Mrs. G. knew that Fred needed something more than a regular class or they would not have kept the appointment. Because the caseworker felt that they were afraid of our program, she tried to help them learn something about the program while she tried to learn something about them.

The caseworker said she knew from the referral material that they had already spent time and money on psychiatric help for Fred and counseling for themselves. She told them she inferred from this that they felt great concern for Fred and that he had a serious problem. "Was his difficulty only something that manifested itself in relation to a poor school situation?" she asked.

After this question, Mrs. G. relaxed a little and both parents described in detail Fred's sickness and the great problems he imposed on family life.

The caseworker pointed out that their observations confirmed the reports. She then said that she wondered if it were possible for a child like Fred to learn in a group of 28 children in a regular school. Both parents agreed that he had not, although the teacher had tried to help him. The caseworker said that Fred's school seemed to have tried its utmost and that it was unlikely that Fred's needs could be met in an ordinary school.

The caseworker then pointed out that, from the description they had given, Fred's case sounded like those of some of the children at LEW, and she described some of them. "How did you feel he might differ from the pupils described?" she asked. Mrs. G. said she was afraid that neither the other children nor our academic program would stimulate Fred. "What," the caseworker asked, "has happened in the past 4 years while he was with children who per-

formed adequately?" He had either withdrawn completely or acted out in an extremely disruptive way, the parents admitted. Mrs. G. felt Fred was bright and that with proper handling he could be brought up to grade level in a short time. The caseworker described LEW's academic program and said with emphasis that, while the school offered stimulation, it was impossible to predict how a child would progress and that disappointment was often inevitable. This statement seemed to free Mr. and Mrs. G. to discuss their disappointment. Mrs. G. cried; Mr. G. looked into space.

By the end of the interview, their fear was somewhat allayed but they still had doubts. The caseworker told them that she felt they should come in again to observe the classes and to discuss the matter once more before bringing Fred in for an interview with the psychiatrist. She pointed out, however, that on the basis of their description and the referral material she was sure Fred needed special schooling. Whether our program was suitable remained to be seen. She also told them that she realized they were full of doubts and were disappointed, but she stressed how important it was to go slowly because much of the success of any program would be their feeling that it was right to try it. They did return for another interview, and after we worked slowly with them, they decided to place Fred with us.

When Mrs. G. brought Fred to school for the first day, she was upset. She wept during the interview and said that the other children "looked sick but not her son." The caseworker told her she understood the anxiety she was going through and that other parents were also anxious. The caseworker held to the belief, however, that Fred did belong in the program. The caseworker made plain to her that the school believed that Fred could be helped. She said that in time, after Fred had begun to adjust to the school and Mrs. G. could see improvement, she would find it easier to accept the placement. The caseworker reminded her that she had had similar feelings when Fred had had other services and that she had come through the experience all right. The caseworker made another appointment for her for a week later and told her to telephone if she had questions before then. At the next appointment, Mrs. G. said she had gotten through the week and that while she still did not like our program, her concern had lessened and the children looked better. The caseworker continued to see her once every 3 weeks for several months, and she gradually became more accepting. Mrs. G. still does not like Fred's being at LEW, but she has been able to support the placement for 3 years in a constructive, meaningful way. From time to time the caseworker must reinterpret Fred's needs to her, give her an opportunity to air her disappointment that he is still ill, and answer her questions.

The personal and marital problems in this family have not changed because of our efforts, but our efforts were influenced by the knowledge of these problems. If we had not understood what was behind the parents' behavior, we could have easily become annoyed with them, particularly with the mother, because Mrs. G. displayed her anxiety through excessive talkativeness, hostility, and projection. Our basic attempt to help was focused on using the family's positive characteristics—their concern for the child and their intellectual awareness. We gave them an opportunity to express their disappointment and pain and to raise their doubts and fears about what a special class might do to their son. We always focused our efforts on reality: their son could not be provided for in a regular class despite all reasonable attempts to help him adjust. We did not attempt to get them to like the placement, only to face it with tolerance. And we gave them the continuing support they required. Ultimately, the boy's gains enabled them to accept the placement with less pain.

Darren's parents

Mr. and Mrs. L. were referred to a special program for their 10-year-old son Darren because of his destructive behavior and failure to learn throughout 4 years in school. One year before referral, he had drawn a knife on another student and as a consequence had been excluded from school. The parents regarded this exclusion as a plot by the school to get rid of Darren, who to them was a quiet, respectful son. To a quiet, withdrawn family, his silence seemed a virtue. The parents considered Darren's flareup in school as a justifiable response to provocation. They resisted special placement, disagreed angrily with psychiatric reports, and threatened to secure legal counsel. When referred to a special program for emotionally disturbed persons, they refused to apply. Darren was out of school a year. Diligent efforts by the school psychologist and the social worker for the special program, coupled with the family's concern for Darren, finally brought the parents to LEW for an interview.

All of the problems already described were evident in the interview. Both parents appeared withdrawn, hostile, and suspicious. The caseworker made clear

For the past 10 years, Joyce Edward has been a psychiatric social worker in the elementary school division of the Luther E. Woodward School for Emotionally Disturbed Children, Inc., Freeport, N.Y., where she works chiefly with the families of severely disturbed children. She received her master's degree in social work from Western Reserve University, School of Applied Social Sciences.

to them that she shared their concern about Darren's being out of school. "What has happened since we spoke to you on the telephone last year?" the caseworker asked. Mrs. L. answered by recounting all of Darren's virtues and placing special emphasis on how helpful he was with the family ironing. The only problem he faced, she said, was not being able to go to school. The caseworker agreed that this was a serious problem. She said their keeping this appointment was a positive step on Darren's behalf, whether or not they found LEW's program suitable. Mr. and Mrs. L. quickly launched into an angry discourse on Darren's former school. The caseworker, after listening for a few minutes, said that she understood their anger but, as they had gone over this many times before without Darren's getting into school, it would perhaps be more helpful to consider the kind of schooling Darren required now.

"You have spent a lot of time with him in the last year; what do you think of his ability to learn? How did he do at school until excluded?" the caseworker asked.

Mrs. L. said that she was surprised that he had not learned to read. Even when she taught him, he did not grasp things, she admitted. When the caseworker asked her if she felt he might need special handling, Mrs. L. said, "Yes." The caseworker then asked if she ever felt that a large class might confuse him. "I guess it could," Mrs. L. admitted. At this point her hostility seemed to lessen, and she began to ask questions about the special school. The caseworker answered her questions by citing facts about LEW and indicated that the program was for children with problems, some similar to Darren's.

Later, when they visited classes, Mr. and Mrs. L. said that some children looked different or "spoke funny." The caseworker agreed that the children were troubled, but she pointed out that she thought Darren had some problems, too. They replied that they did not think he was like the other children, but Mrs. L. felt he should go to school and perhaps it would be best to place him in LEW.

The caseworker, moving slowly, in some ways mirrored their resistance. She said she could not say immediately whether this was a good plan for Darren; the school psychiatrist and psychologist would have to see him and give a lot of thought to the matter. Perhaps home teaching was best. At this the parents immediately suggested that the intake study be conducted.

Darren was accepted, and his parents were willing for him to go to LEW by the time he was placed. In the first interview after placement, Mrs. L. came alone; she said that her husband would not be able to come. As she saw it, the family's problems with the school were really her responsibility. We did not insist upon the father's coming, although we usually try to work with both parents.

Mrs. L. immediately complained that Darren's sweater had been torn in class, and she asked whether the teacher was supervising the class properly. The caseworker told Mrs. L. she knew how hard it must be for her to have Darren's clothing torn, with prices as high as they are and a large family to clothe. Mrs. L. then related in detail the concern her many bills gave her. The caseworker let Mrs. L. know that she felt her concern was realistic and her management on a small income, competent. After this, Mrs. L. seemed less hostile. Darren had made a good start, and the caseworker gave her examples of what he was doing. She admitted that he appeared pleased about school, which was unusual for him. Mrs. L. said she guessed that with boys one had to expect a tear or two. The caseworker agreed, but told her she would bring the matter of the tear to the attention of the teacher. The caseworker then asked her if she would like to meet the teacher and see Darren's class. She said, "Yes." The visit delighted her, especially Darren's pleasure in introducing her to his class.

Mrs. L. now has appointments monthly with us, which she always keeps. During these interviews the caseworker shares with her information about Darren's progress in school, which has been slow but consistent. Darren no longer acts out as he used to, a change that has confirmed his need for the program to the parents. Mrs. L. has been gratified by the academic gains, too. The causes of some of Darren's problems come to light now and then in what she says. We asked her once about Darren's laughing at times when nothing seems to be happening. Mrs. L. said she had noticed this and thought she laughed the same way. Often she has funny thoughts that

cause her to laugh and she thought everyone else did too. We did not pursue this matter, nor did we deal with other obvious indications of family pathology. Mrs. L. developed a friendly feeling for the school. She told us how much it meant to her that there were no complaints about Darren. Although she continued to feel he was not like the other children, she thought that he was learning and that since we were not making him angry he should remain another year.

We never attempted to help Mrs. L. to understand Darren's real problem. All previous efforts in this direction had only stimulated her anxiety and tendency to act out. We worked with her as she was and tried to make the most of her concern for Darren's education. As he improved her anxiety lessened.

A focus on responsibility

There still are and will continue to be many problems in these families. No basic alteration in the personalities of the parents have been made, nor have we touched the core of their relation with their children. We have, instead, tried to enable them to allow their children to take advantage of an opportunity for special education without interference. We have focused our efforts on stimulating feelings of responsibility rather than stirring feelings of guilt. We believe that through this process some of the parents' anxiety was diminished and that a more pleasant atmosphere was created at home, thus lessening the strain that builds up when tension between home and school is strong.

When we assume responsibility for the education of the emotionally disturbed child, we assume an imposing task. It is not placing a child in a "special" class that makes his education "special," however; rather it is the recognition of his many complex needs and an interweaving of the insight and skill of various professions to meet these needs. To do this, we must have concern for many aspects of the child's life, including the role his family plays in relation to his schooling. The most capable teacher, the finest curriculum, the most expert clinical service will be of little avail if the child's family refuses to accept a program for him or, in placing him, sabotages the school's efforts.

guides and reports

FAMILY LIFE EDUCATION—A CAUSE FOR ACTION. American Social Health Association, 1740 Broadway, New York, N.Y. 10019. November 1966. 64 pp. $2.

Reports on a demonstration project conducted over 9 years by the American Social Health Association in 23 States and the District of Columbia through which family life education programs were incorporated in the curriculums of public schools and teacher training institutions.

BIRTH CONTROL POLICIES AND PRACTICES IN FIFTY-EIGHT CALIFORNIA COUNTY WELFARE DEPARTMENTS. Carl Reiterman. Planned Parenthood of Alameda County, 482 West MacArthur Boulevard, Oakland, Calif. 94609. 1966. 102 pp. $4.

Reports on a survey of the policies of California's county welfare departments concerning the provision of contraceptive services or advice.

CHILD LIFE PROGRAMS IN 91 PEDIATRIC HOSPITALS IN THE UNITED STATES AND CANADA. Robert H. Dombro. Child Life Program, Children's Medical and Surgical Center, Johns Hopkins Hospital, Baltimore, Md. 21205. 1966. 18 pp. 50 cents. (Mimeographed.)

Reports the findings of a survey of the characteristics of recreational and educational programs for children in 91 children's hospitals.

LISTEN EVERYBODY! YOUTH PARTICIPATION IN COMMUNITY ACTION: report of a demonstration training project. California Department of the Youth Authority, 401 State Building No. 1, Sacramento, Calif. 95814. 1967. 66 pp. Copies free on request from the Department.

Reports on a 1-year demonstration project in which 182 young people from impoverished areas in California were trained to work in community improvement programs. Sponsored by the Governor's Advisory Committee on Children and Youth and financed by the Office of Economic Opportunity, the project was administered by the California Department of the Youth Authority.

UNDERSTANDING THE DISADVANTAGED: a source book. School of Home Economics and Extension Division, University of Missouri. Available from the Technical Education Services, University of Missouri, 417 South 15th Street, Columbia, Mo. 65201. 1966. 187 pp. $1.

The proceedings of a short, interagency, interdisciplinary course in studying the disadvantaged held at the university of Missouri, July 13–15, 1965.

BOOK NOTES

TOUGH TIMES AND TENDER MOMENTS IN CHILD CARE WORK. Eva Burmeister. Columbia University Press, New York. 1967. 274 pp. $6.

Through child-care workers' own descriptions of incidents that have occurred in their work with institutionalized children as well as through the author's comments, this book not only presents some of the problems and principles of caring for groups of children living away from home but also gives a picture of the emotional needs and confusion common among such children. The incidents, originally described by the child-care workers as assignments in inservice training classes, are presented by the author as illustrations of points she makes in regard to specific aspects of a child-care worker's responsibility, such as the relationship with the child; finding the feelings behind a child's verbal communication; recognizing and dealing with the mood of the group; understanding a rejected child's mixed feelings about his parents; encouraging creativity in the children; and handling difficult behavior.

In the final chapter, the author points to the importance of providing training opportunities for houseparents, who in many instances themselves feel an urgent need for more competence in helping the unhappy children have happier lives. She points out that, increasingly, the children placed in institutions arrive with serious emotional problems derived from their previous experience in family and community.

JUVENILE GANGS IN CONTEXT: theory, research, and action. Edited by Malcolm W. Klein in collaboration with Barbara G. Myerhoff. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1967. 210 pp. $3.50.

The 15 papers in this symposium discuss the nature and causes of gang juvenile delinquency and the effectiveness of methods of working with street gangs through "detached" workers to bring about constructive change. They are presented under four heads: patterns of gang behavior, relation between perceptions and behavior, sociological contexts, and action programs. The authors include administrators, practitioners, and research workers in programs of delinquency prevention. The last section describes programs in New York City, Chicago, and Washington, D.C.

ADOLESCENCE: care and counseling. Edited by Gene L. Usdin, M.D. J. B. Lippincott Co., Philadelphia, Pa. 1967. 238 pp. $7.

Stressing the need for understanding (and the "desire" to understand) the adolescent in his struggle to find his identity in today's world, this group of papers by psychiatrists and other physicians is directed to professional persons, especially physicians, to whom adolescents are most likely to turn for help with problems. The papers discuss the normal, physical, and psychological changes of adolescence and adolescents' relationships with adults, as well as the effects of social change on adolescents and on the nature of the adolescent subculture.

Some of the specific problems discussed are religious-psychological conflicts, sexual morality, disguised depressions, learning problems, antisocial tendencies, the effects of drugs used in treating emotional disturbance, and parents of adolescents with problems.

In his introduction, the editor finds "healthy signs" in the increased openness of adolescents about their behavior and values, which he sees as representing "an honest groping toward a new and more complete maturity." Calling for more responsible leadership from adults in helping adolescents to reach this goal, he points to the often overlooked opportunity presented to physicians to provide them with effective counseling. Adults, he points out, should not lose sight of the "ageless truth" that adolescents "are the product of the times and not the source of our difficulties."

These papers were presented at a symposium on adolescence held in December 1966 by the Touro Community Mental Health Center of New Orleans with a grant from the National Institute of Mental Health.

PARENTS, CHILDREN, AND ADOPTION: a handbook for adoption workers. Jane Rowe. Humanities Press, New York. 1966. 294 pp. $6.

The unmarried mother and her child are the central figures in this book, which brings together information from the fields of medicine, genetics, psychology, law, and social work in discussing the theory and practice of social casework in services to unmarried mothers and in child placement for adoption. In discussing work with the natural parents of a child born out of wedlock, the author stresses the importance of working with the father as well as with the mother. The aspects of adoption she discusses are: heredity and environment as they affect the child; homefinding, planning for placement, and placement; the legal procedures; and supervision of the adoptive home.

The author has worked in the child welfare field both in her native England and in the United States.

CASEWORK WITH FAMILIES AND CHILDREN. Edited by Eileen Young-husband. University of Chicago Press, Chicago, Ill. 1966. 175 pp. $1.75 (paperback).

A collection of 14 articles reprinted from British and U.S. social work journals and other publications, this book discusses the family from three viewpoints, indicated by the titles of its three sections: (1) concepts of the family; (2) toward a deeper understanding; and (3) treatment. Among the topics of papers in the first section are "Concepts Relevant to Helping the Family As a Group" and "Social Determinants of Family Behaviour"; in the second, "The Normal Family—Myth and Reality," "Chronic Sorrow: A Response to Having a Mentally Defective Child," and "Children at Risk"; and the third, "Treatment in the Home," "Helping a Child Adapt to Stress: The Use of Ego Psychology in Casework," and "Applying Family Diagnosis in Practice."

HERE and THERE

Against poverty

Thirty-six communities have applied to the Office of Economic Opportunity for planning grants of $10,000 each to develop programs of comprehensive services for families with young children under the pilot program, "parent and child centers," announced by the President last February in his message to Congress on the welfare of children (see CHILDREN, March–April 1967, p. 85). Their plans will focus on helping families living in areas of poverty who have children under 3 years of age meet whatever needs may be interfering with the children's healthy development.

To be approved for operational grants, the plans must be submitted within 6 months after the planning grant has been received and must include built-in methods for evaluating, which are tied into a university in some way. A portion of the funds for Project Head Start has been earmarked for the new program.

The 36 communities were invited to apply on the recommendation of a Federal interdepartmental steering committee representing the Office of Economic Opportunity, the Bureau of the Budget, and three Federal departments—Housing and Urban Development, Labor, and Health, Education, and Welfare. Geographically, they are located in various parts in the United States, from Hawaii to Vermont, and include 22 cities and 10 rural communities. Among the latter are an Indian reservation in South Dakota, a community of agricultural migrants based in Pasco, Wash., and an Eskimo village in Alaska. Fourteen of the cities will develop multiple-service neighborhood centers under another program, and these will be coordinated with the parent and child programs.

The OEO and the cooperating Federal agencies held a 2-week orientation seminar in Washington, D.C., September 11–22, for persons who would be involved in the local planning and in program evaluation. Thirty-one of the thirty-six communities sent such representatives, and a few also sent representatives of the potential users of the services. Also attending the seminar were part-time "project officers," appointed by OEO to give consultation to the communities on both planning and program operation, and members of an HEW consortium—composed of persons from the Children's Bureau (representing the Social and Rehabilitation Service), the Office of Education, and the Public Health Service—which has been working with OEO on the development of program standards. A special feature of the seminar was site visits by small groups to Rochester and Syracuse, N.Y., New York City, and Greensboro, N.C., to see various types of programs for parents and young children, including group day-care and family day-care programs.

. . .

The Ventura County (Calif.) Welfare Department has adopted as a permanent program a work experience and training project that provides work training for mothers receiving assistance under the Aid to Families with Dependent Children (AFDC) program and low-cost day-care service for their children while they are in training. Completely supported for 2 years with Federal funds under the Economic Opportunity Act through the Welfare Administration, U.S. Department of Health, Education, and Welfare, the program now receives State and local support matched by Federal funds under the Social Security Act.

Through two centers, one in Oxnard and the other in the city of Ventura, the project offers mothers in the AFDC program opportunity to obtain basic education; high school equivalency courses; on-the-job training as teacher assistants and general education aides; instruction in child care, the preparation of food, home maintenance, and housekeeping; broad social services to help them solve family problems; and vocational and educational counseling and guidance. Each center provides day-care service for the trainees' children, staffed by other trainees under professional supervision. For this the mothers are charged $5 a month; the project absorbs the rest of the cost. This low-cost day care is available to the mothers even after they become self-supporting.

During the first 2 years of the program, when it was a Federal project, over 132 mothers took part. Of the 47 completing the course, nearly all have found employment and 23 have been able to withdraw from the AFDC program.

Against smoking

How to protect the public from the health hazards of smoking received the concentrated attention of nearly 500 persons from 30 countries meeting together in New York City on September 11–13, at the World Conference on Smoking and Health.

The conference was held under the auspices of the Interagency Council on Smoking and Health, an association in this country of national voluntary and governmental agencies concerned with the effects of cigarette smoking on health. Its participants included administrators and health educators from governmental and voluntary health agencies; biological and behavioral scientists and science writers; educators; leaders in agencies serving youth; and representatives of the tobacco industry, the press, and the radio and television industries.

Featured speakers outlined congressional proposals for regulating cigarette advertising and the tar and nicotine content of cigarettes; presented research findings showing a higher incidence of morbidity among smokers than nonsmokers; reported on efforts to produce a "safer" cigarette; and discussed ways of helping people, particularly young people, to refrain from smoking.

In 10 work groups the participants focused their attention on various aspects of the smoking problem, including research on how the habit is formed, the responsibility of the media of mass communications, and antismoking programs in school and other ways of influencing young people.

Throughout the conference there was a strong emphasis on the importance of influencing young people against smoking before they start to smoke, on the necessity of getting at the young people through "exemplars," the adults and peers whom they admire.

. . .

The American Heart Association has recently issued a leaflet, "What To Tell Your Parents About Smoking," which is being distributed through local heart associations to children and young people through elementary and secondary schools, Girl Scout and Boy Scout groups, 4–H Clubs, church groups, and parent-teacher associations. With the purpose of helping "convince both youngsters and their parents that cigarette smoking is a health menace," the leaflet cites scientific studies pointing to the relation between smoking and heart disease, lung cancer, emphysema, and chronic bronchitis.

Child welfare

The majority of adolescents who run away from suburban homes are responding in a particular way to problems common among adolescents—difficult relations with their parents, their schools, and their peers—according to the findings of a study carried out in Prince Georges County, Md. (adjacent to Washington, D.C.), by the National Institute of Mental Health. For only a small portion of those studied was the running away connected with individual or family pathology.

The investigators gathered data on the social and family characteristics of 631 children aged 10 through 17 who had run away from home in the year ended July 31, 1964, and similar data on a control group of 1,350 students attending 11 local public secondary schools.

The data collected were obtained from police reports on missing persons; in followup interviews with parents and the runaways themselves; from school, police, and court records; and from questionnaires filled out by the students in the control group. Three-fourths of the runaway children never got beyond the Washington metropolitan area; almost two-thirds were found within 48 hours; half returned home on their own.

Only 52 percent of the runaways lived with both natural parents, as compared with 82 percent of the student respondents. However, over 80 percent of the student respondents reported having trouble at home. About 75 percent of the runaways had conflict within the family, mainly over issues such as the child's school performance, choice of friends, and rejection of family rules and values, according to their parents' reports.

Two-thirds of the runaways had school problems, according to their parents; an equal proportion of the student respondents said they had school problems. School records, however, showed that runaways had more school problems than student respondents. Among the runaways, 58 percent were school dropouts at the time they ran away.

About 40 percent of the runaways belonged to clubs, as compared with 80 percent of the student respondents. Only 50 percent of the runaways had paid employment, as compared with 85 percent of the controls. One out of three runaways had had one or more contacts with the police in the 2 years preceding the missing persons report, according to juvenile bureau records. The same proportion of contacts with police was reported by the control group; but one out of every six runaways had had a charge placed against him, as compared with only one out of 25 in the control group.

Of the runaways, 220 were repeaters. Among the repeaters, 63 percent came from families who had incomes between $6,000 and $12,000, as compared with 56 percent of the total group of runaways. In both groups, 28 percent came from families with incomes under $6,000.

Three-quarters of the repeaters were said by their parents to be having trouble in school, as opposed to one-half of the one-time runaways. School records also showed that repeaters had more school problems than one-time runaways.

The study is reported in detail in a monograph issued by the Society for Research in Child Development entitled "Suburban Runaways of the 1960's" (available from the University of Chicago Press, 5750 Ellis Avenue, Chicago, Ill. 60637, price: $3).

. . .

The Presbyterian Institute for Human Development, located in Louisville, Ky., recently set up a national child-care information center to collect, store, retrieve, and "package" material on residential group care for children; and the School of Social Work of the University of North Carolina, Chapel Hill, has developed a preliminary system of indexing and processing for the center to use to prepare the most urgently needed material. The first material to be processed will be on group care for dependent and disturbed children and on services to their families provided by public and voluntary child welfare institutions and agencies.

. . .

The Child Welfare League of America recently issued a memorandum to its members pointing out that the league "views the development, extension, and improvement of child welfare services for the mentally retarded child and his family" as an appropriate and timely concern for league affiliates. The memorandum points out that only a fraction of the children known to be retarded are receiving child welfare services. It maintains that where such services have been provided by child welfare agencies they have proven to be beneficial, and that providing them has involved only slight adaptation of basic child welfare principles, knowledge, and methods.

Bussing and buses

Children who transfer under a desegregation plan from schools in disadvantaged areas to schools in advantaged areas are still entitled to the special educational benefits offered by title I of the Elementary and Secondary Education Act of 1964 for children from low-income families, according to a policy statement recently sent by the U.S. Commissioner of Education to all chief State school officers. Under title I, schools in designated poverty areas offer children special programs in health, nutrition, and social services;

guidance and counseling; and remedial work. Each school district will work out its own method of having title I programs follow children who transfer from one school to another by plan, the Commissioner's statement points out.

. . .

Few schoolbuses adequately protect children from injury or even death in a collision, according to the findings of a study of schoolbus passenger protection made last year by the Institute of Transportation and Traffic Engineering and the Department of Engineering, University of California at Los Angeles, with support from the U.S. Public Health Service and the National Safety Council. The study indicated that the greatest protection for a child in a schoolbus during a collision is a high-strength, high-back safety seat, and that few buses had them.

To gage the safety of schoolbuses and to determine ways to make them safer, the institute staged three accidents by mechanical means involving schoolbuses: two schoolbuses were made to meet head on at 30 m.p.h.; a passenger car traveling at 60 m.p.h. was made to strike a stationary bus from the rear; and a passenger car traveling at 60 m.p.h. was made to strike a stationary bus from the right side. Each bus carried anthropometric dummies of children corresponding to ages 3, 6, and 13, and of adults. After the collisions, the experimenters checked seats, restraint systems, and the performance of the buses and analyzed the effects on the dummies, seat by seat.

The institute's recommendations for improving the safety of schoolbuses include these:

- Seats, in addition to being very strong and having backs at least 28 inches high, should have well-padded armrests and harnesses or lap belts.
- The passenger compartment should be securely attached to the frame of the bus by shear bolts placed at frequent intervals from front to rear and along both seats in a frame.
- Protruding, rigid structures should be eliminated.
- Drivers of schoolbuses should always wear at least a lap-type safety belt when the bus is in motion to insure that they will remain behind the wheel during an accident.
- Buses should have at least four clearly marked exits.
- Schools should conduct emergency exit drills for children who ride schoolbuses to insure quick evacuation, particularly in case of fire.

Nearly 3,700 children were injured in schoolbus accidents in 1965, according to estimates of the study.

READERS' EXCHANGE

VIETNAMESE CHILDREN: *two different views*

The position taken by the Commission on International Social Welfare of the National Association of Social Workers, as reported in the "Here and There" section of the July–August 1967 issue of CHILDREN ("Child Welfare," p. 166), regarding war-injured Vietnamese children is regrettable, to say the least.

Let me address myself to three of the four points the Commission made:

1. "The greatest effort should be directed to reuniting children with their own families."

2. "Institutional care of children outside the family should be considered only as a last resort and a temporary measure."

4. "Under no circumstances should children and their needs be used to influence political opinions in regard to United States involvement in Vietnam."

All three of these points may be dismissed. The Committee of Responsibility, Inc. (COR), which has been attempting to bring critically injured Vietnamese children to this country for treatment, is composed of persons who are willing to set aside their varied personal views on Vietnam in a very real concern for those child victims of the war for whom the expert medical-surgical care needed is simply *not available in Vietnam.*

When confronted with this fact, points one and two are meaningless—as meaningless as though the Commission were to apply them to a severely physically handicapped American child and conclude that the child should remain with his family rather than receive the medical-surgical care he needs, available only at a distant hospital.

Regarding point four, let me assure the Commission that our financial contributions come from both conservatives and liberals.

The one point that is appropriate is three:

3. "Children should only be removed to other countries for needed service in exceptional circumstances, and then all human rights of the children, including the right to return home, must be protected."

This is the exact position of COR.

From July 29 to August 7, two physicians representing COR were in Vietnam to: conclude arrangements with the Minister of Health for evacuation of four war-injured children selected by COR's medical team; and establish a formal basis for a continuing program of case selection and evacuation. Neither of the two goals was achieved, although general principles of operation were agreed upon and a joint communique was issued from the Minister of Health and the COR physicians outlining areas of concurrence.

The failure to achieve immediate success was induced by an evermore complex labyrinth of ministry regulations. The COR doctors were particularly dismayed by these administrative difficulties in view of the needs they witnessed at the six provincial hospitals they visited in I Corps, where much of the recent fighting has occurred.

In these hospitals the load of civilian casualties with amputations, burns, infections, wounds, and fractures of all descriptions precludes any but short range, life-saving care. While the doctors there—American military doctors, European and American volunteers—are dedicated, conscientious, hard working, they cannot meet the need with their inadequate staff and facilities.

COR cannot meet the needs of all

such civilian casualties, for their numbers increase with every increase in the war. However, there are many wounded children for whom a chance to function again could be provided through the skills and technology of the hundreds of U.S. medical specialists and the 20 major medical centers that have volunteered to serve them in the U.S.A.

We have asked the president of the National Association of Social Workers to ask the board of directors of NASW the following question: When an injured Vietnamese child desperately requires treatment *not* available in Vietnam, will NASW support the COR program of transportation to the United States for treatment?

Rex Ragan
Board Member, Los Angeles Committee of Responsibility, Inc.

A reply

It is to be regretted that Mr. Ragan has chosen to base his comments on out-of-contact excerpts from the letter sent to President Johnson by NASW's Commission on International Social Welfare concerning the care of children in Vietnam. I believe it is important to restate in full all four of the principles "of child welfare as they apply to Vietnamese children and their families" as set forth in the Commission's letter:

"1. All efforts must be made to have every child grow up within his own family as a healthy human being. To this end, greatest and primary emphasis must be placed on keeping or reuniting children with their own, including their extended, families. Families need to be assisted in keeping their children through a vastly extended, improved network of social services and institutions, including if possible a system of family supports (in kind and in money). Institutional care of children outside the family is sometimes necessary to meet immediate needs. However, this kind of child care should be considered as the *last resort* and as a *temporary means only* and should be used to facilitate the reintegration of the child into normal family life.

"2. The efforts of the American social work profession, the American public, and the United States Government should be directed toward strengthening, extending, improving and financing such services in Vietnam. Except in exceptional circumstances children, as a matter of principle, *should not be removed to other countries to receive needed services.* When children are removed from their countries, all of their individual human rights, including the right to return home, must be safeguarded.

"3. To strengthen, expand and improve needed services in Vietnam, the training of professional and semiprofessional personnel is an urgent necessity. Therefore, training programs for such personnel should be vastly and immediately expanded in Vietnam and in this country.

"4. Under no circumstances shall children and their needs be used as means of influencing political opinions concerning our country's involvement in Vietnam."

I cannot dismiss these points as "meaningless" as they relate to the needs of children I observed in a 4-week visit to South Vietnam this past summer. We have an obligation to see that children are not separated from their families or torn from their cultural moorings except as a very last resort. Children in Vietnam need a variety of specialized services. An alternative to bringing a few children to this country to receive these services is to seek to make these services available to them in their own country. Children need their own families, or those who can best substitute for them, especially when they are in need of medical care.

In its letter to the President, the Commission made it clear that "American social workers, like other Americans, differ in their views about this country's involvement in Vietnam, but are united in their deep concern for the plight of the Vietnamese people, and especially their children." The answer to any request to NASW concerning support of any program for children, whether here or abroad, I hope, will be dictated solely by that concern.

James R. Dumpson
Chairman, Commission on International Social Welfare
National Association of Social Workers

BURNS AND GOODMAN: *some questions*

The article, "The Teaching Homemaker in a School Project," by Mary E. Burns and Julia Ann Goodman, [CHILDREN, September–October 1967] illustrates the versatility of the many elements in homemaker service. The teaching of better methods of child rearing and of household management has been an implicit function of this type of service for a long time, but in this experiment of the Highland Park school system's Pupil Adjustment Project, teaching was selected as an explicit function.

The efforts, skill, and imagination of all participants in this thoughtfully designed and professionally well-fortified program converged in helping children from disorganized families and their parents to develop their capacity for achieving social health, thus freeing children to learn and increasing the self-respect of parents and their involvement in the mainstream of educational and social activities.

Recognizing that the description of any project raises more questions than can be answered in one article, I still should like to have learned more about the dynamics of family participation and change in this program. For example, how were the services of the teaching homemakers presented to the families and what were their reactions to having been selected to participate in them? What help was given to the families when situations arose that required other forms of homemaker service? What plans were made for helping families to sustain their gains after the teaching homemakers left the home?

Although casework was the foundation of the program, apparently the homemakers carried out some responsibilities that belonged to the caseworkers such as helping the families in their use of community resources. Since helping families with their needs for other services and their feelings about these needs and motivating them to effectively incorporate these services require casework competence, how was the duplication in responsibilities resolved?

The tangible services of the two teaching homemakers helped to build practical bridges connecting the children and their families with the comprehensive services of the school system. I hope that a detailed report of this creative project will soon be available, for it would undoubtedly provide refreshing topics for staff discussions, seminars, and workshops as well as ideas for planning services.

Nora P. Johnson
Assistant Executive Director
The Children's Aid Society
New York, N.Y.

U.S. GOVERNMENT PRINTING OFFICE: 1967

U.S. Government Publications

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

CHILDREN WHO NEED PROTECTION: an annotated bibliography. Compiled by Dorothy M. Jones. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1966. 75 pp. 30 cents.

Lists 463 selected publications on child neglect, most of them published in the last 25 years. The subjects include: child abuse; child welfare; foster home care; homemaker services; juvenile and family courts; maternal deprivation; medical aspects; mental health; parent-child relations; protective services; social casework.

STUDIES IN DELINQUENCY: ALTERNATIVES TO INCARCERATION. LaMar T. Empey. THE REENTRY OF THE OFFENDER INTO THE COMMUNITY. Elliot Studt. THE CULTURE OF YOUTH. Marvin E. Wolfgang. Department of Health, Education, and Welfare, Welfare Administration, Office of Juvenile Delinquency and Youth Development. JD Publication Nos. 9001, 9002, and 9003. 1967. 88 pp., 40 cents; 22 pp., 20 cents; 29 pp., 20 cents, respectively.

The first report analyzes the correctional process and examines efforts concerned with establishing alternatives to incarceration; the second examines the parole process and focuses on conditions affecting the offender's success or failure as a parolee in the community; the third discusses beliefs and standards of young people and their influence on deviant behavior.

HOMEMAKER SERVICE: how it helps children. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 443. 1967. 24 pp. 35 cents.

Explains what a homemaker service is, why it is needed, how it is used to help families, and what the development of such a service in a community involves. Includes case histories.

A DEVELOPMENTAL APPROACH TO CASEFINDING WITH SPECIAL REFERENCE TO CEREBRAL PALSY, MENTAL RETARDATION, AND RELATED DISORDERS. Una Haynes. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 449. 1967. 85 pp. $1.25.

A guide to assist nurses in early recognition of deviations in normal patterns of growth and development of infants and young children that are symptomatic of anomalies or dysfunctions, especially in the basic neurological reflex patterns and the maturation of the central nervous system. Includes a wheel guide showing normal milestones in development in the first 36 months of life.

"RED IS THE COLOR OF HURTING"—PLANNING FOR CHILDREN IN THE HOSPITAL: based on proceedings of the workshop on mental health planning for pediatric hospitals at the annual meeting of the American Orthopsychiatric Association, New York, April 1965. Milton F. Shore, editor. Department of Health, Education, and Welfare, Public Health Service, National Institute of Mental Health. PHS Publication No. 1583. 1967. 94 pp. 55 cents (paperback).

Contains six papers and discussions ensuing from them on changes needed in hospital pediatric inpatient facilities and in patterns of care to help young children through the stress of short-term hospitalization.

---

photo credits

Frontispiece and page 225, James Foote, for the Children's Bureau.

Page 213, *Better Homes and Gardens.*

CHILDREN is published by the Children's Bureau six times a year. Use of funds for printing this publication was approved by the Director of the Bureau of the Budget, September 21, 1962.

NOTE TO AUTHORS: Manuscripts are considered for publication only if they have not been previously published. Speeches from conferences should carry appropriate identification. Opinions of contributors not connected with the Children's Bureau are their own and do not necessarily reflect the views of CHILDREN or of the Children's Bureau.

Communications regarding editorial matters should be addressed to:

CHILDREN
Children's Bureau
U.S. Department of Health, Education, and Welfare
Washington, D.C. 20201

Subscribers should send payment directly to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

CHILDREN is regularly indexed by the Education Index and the Nursing Literature Index

UNITED STATES GOVERNMENT PRINTING OFFICE, WASHINGTON, D.C. 20402, 1967

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402
Price 25 cents a copy. Annual subscription price $1.25. 50 cents additional for foreign subscriptions.

21

UNITED STATES
GOVERNMENT PRINTING OFFICE
DIVISION OF PUBLIC DOCUMENTS
WASHINGTON, D.C. 20402

OFFICIAL BUSINESS

POSTAGE AND FEES PAID
U.S. GOVERNMENT PRINTING OFFICE

BUILDING
USE ONLY

children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

published 6 times annually by the

U.S. DEPARTMENT
of HEALTH,
EDUCATION,
and WELFARE
John W. Gardner, *secretary*

SOCIAL AND REHABILITATION SERVICE
Mary E. Switzer, *administrator*

CHILDREN'S BUREAU
Katherine B. Oettinger, *chief*